

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08888

08887

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellerslie			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clifford Middle Orlanda Last Albright				4. DATE OF DEATH Month July Day 27 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 20, 1900		9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months 27 Days 19 Hours 67 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bus Company Operator		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ellerslie, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Albright				14. MOTHER'S MAIDEN NAME Alice Hayman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-32-3188		17. INFORMANT Mrs. Martha Albright		Address Ellerslie, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) -----							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED July 27, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox				ADDRESS 21502		25a. REC'D BY REGISTRAR JUL 31 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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TO DEPUTY: CAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A1SME
SM 9/60

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FOR STATE
HEALTH DEPT

088889

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

088889

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. Va. b. COUNTY Mineral	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) McCoole		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Keyser	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. 220		d. STREET ADDRESS Rt. 4	
3. NAME OF DECEASED (Type or print) Douglas K. Allamong		4. DATE OF DEATH July 23, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 Jan 1935
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Analyst		10b. KIND OF BUSINESS OR INDUSTRY Paper Ind.	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Gladson Allamong		14. MOTHER'S MAIDEN NAME Beatrice Camp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Helen Allamong	
17. INFORMANT Helen Allamong		Address Rt 4 Keyser, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO (Auto-Motorcycle Accident) Conditions, if any, which gave rise to immediate cause (b) (Auto-Motorcycle Accident) (c) (Auto-Motorcycle Accident) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Driver of Motorcycle involved in accident	
20c. TIME OF INJURY Month, Day, Year 2:30 p.m. July 23 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> el work <input type="checkbox"/> el work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) McCoole, Allegany, Maryland		20f. (City or town) Keyser (County) Allegany (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelid		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER July 23, 1967	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 July 67	
22c. NAME OF CEMETERY OR CREMATORY Potomac Valley Park		22d. LOCATION (City, town, or country) Keyser, W. Va.	
23. FUNERAL DIRECTOR Allen M. Rotruck		24. REC'D BY REGISTRAR JUL 26 1967	
ADDRESS Keyser, W. Va.		REGISTRAR'S SIGNATURE Charles J. J...	

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 815 BROOKFIELD AVE.	
3. NAME OF DECEASED (Type or print) First JERRY Middle BEECHE Last BEECHE		4. DATE OF DEATH Month JULY Day 19 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1901
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LOUIS BEECHE	
14. MOTHER'S MAIDEN NAME LOISE TAYLOR		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 214-05-9413		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO Gravely arteriosclerosis (b) Coronary Disease DUE TO Coronary Disease (c) Coronary Disease		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 14, 1967 to July 19, 1967 , that (I) (we) lost saw the deceased alive on July 19, 1967 , and that death occurred at 12:45 PM on the date stated above.			
22a. SIGNATURE Blane M. Schindler		22b. DATE SIGNED 7/24/67	
22c. PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.		22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Park	23d. LOCATION (City or Town) (County) (State) Near Cumberland Md. Alleg.
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25. REC'D BY REGISTRAR DATE JUL 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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88280

ALLERBY

CUMBERLAND

MEMORIAL HOSPITAL

JERRY

WALL WHITE

RETIRED

LOUIS BECHTOLD

ALLERBY

WALL WHITE

CUMBERLAND

MEMORIAL HOSPITAL

BECHTOLD

7-3-1901

CUMBERLAND, MO.

LOUIS BECHTOLD

MEMORIAL HOSPITAL, CUMBERLAND, MO.

STATE OF MISSOURI, W.D., 13 GREENE ST., CUMBERLAND, MO.

JUL 8 1988

CERTIFICATE OF DEATH

08891

08890

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 14 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 408 MARYLAND AVE.	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM BLAIR		4. DATE OF DEATH Month Day Year JULY 1 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-11-1893
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY KELLY S.T.CO.	
11. BIRTHPLACE (County & State, or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME JOHN BLAIR		14. MOTHER'S MAIDEN NAME JENNIE STEWARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 1		16. SOCIAL SECURITY NO. 14 05 9635	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior & Posterior - Coronary disease DUE TO (c) 5 yrs.		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Cecum.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 26, 1967 , to July 1, 1967 , that (I) (we) last saw the deceased alive on July 1, 1967 , and that death occurred at 5:45 PM from causes and on the date stated above.			
22a. SIGNATURE D.B. GROVE		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) D.B. GROVE, M.D.		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR JUL 6 1967	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08892

08891

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS 414 Park Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital--DOA		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HARVEY C. BRAITHWAITE		4. DATE OF DEATH Month Day Year July 4, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 20, 1893
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jackson Braithwaite		14. MOTHER'S MAIDEN NAME Ida Stotler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-3953	
17. INFORMANT Mrs. Guy Smeight		Address Martinsburg, W. Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) ---			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 4, 1967 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 8, 1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Whitacre-Frederick Co. Va.
24. FUNERAL DIRECTOR William G. Kight		ADDRESS Cumberland, Md.	
25a. REC'D BY REGISTRAR JUL 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

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VR A15ME
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08893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08892

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN b. 65 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS Route 4 Oldtown Road	
3 NAME OF DECEASED (Type or print) First Benjamin Middle Sanford Last Brake		4 DATE OF DEATH Month July Day 23 Year 19 67	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1885
9 AGE (In years <1 birthday) yrs 81		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) French Creek, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac W. Brake		14. MOTHER'S MAIDEN NAME Mary Hartman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 705-07-6846	
17. INFORMANT William R. Brake, Cumberland, Md.-Son		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Uremia DUE TO (b) Hypernephroma of Kidney DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		22. DATE SIGNED JULY 23, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> JULY 23, 1967 Address (Street, city, town, or county) CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 26, 1967	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or town) (County) (State) Cumberland, Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUL 26 1967	
		25b. REGISTRAR'S SIGNATURE <i>James F. Scarpelli</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 1 week	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage R.D. #1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		d. STREET ADDRESS 1	
3 NAME OF DECEASED (Type or print) First Elmer Middle E. Last Bridges		4. DATE OF DEATH Month July Day 9 Year 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 17, 1901
9 AGE (In years lost birthday) 66 yrs		10 UNDER 1 YEAR Months 1 Days 22	11 UNDER 24 HRS Hours 1 Min. 22
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refractory worker		10b KIND OF BUSINESS OR INDUSTRY Refractory	
11 BIRTHPLACE (County & State, or foreign country) Allegany, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Abraham Bridges		14. MOTHER'S MAIDEN NAME Rosetta Diehl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-03-7173	
17. INFORMANT Mrs. Leona E. Bridges		Address Mt. Savage Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute brain syndrome 447X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Circulatory disturbance (c) Hypertensive vascular disease			INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 8, 1967 , to July 9, 1967 , that (I) (we) last saw the deceased alive on July 9, 1967 , and that death occurred at 11:20 PM , from causes and on the date stated above.			
22a SIGNATURE A. Paige Strong		22b. DATE SIGNED July 10, 1967	
22c. PHYSICIAN'S NAME (Type) A. Paige Strong		22d. ADDRESS 167 East Main St. Frostburg Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 12, 1967	
23c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Park		23d. LOCATION (City or Town) (County) (State) LaVale Allegany Md.	
24. FUNERAL DIRECTOR Beulah H. Montesant		25a. REGD. BY REGISTRAR Hafer-Sowers Funeral Home	
25b. REGISTRAR'S SIGNATURE Charles J. Jago		DATE JUL 13 1967	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME (5)
SM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND c. COUNTY ALLEGANY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN ID 1 HR.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 517 OLDTOWN RD.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN CASPER BRINKER		First Middle Last		4. DATE OF DEATH 7 24 1967		Month Day Year			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3 5 1893	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROOFING CONTRACTOR		10b. KIND OF BUSINESS OR INDUSTRY SELF EMP.		11. BIRTHPLACE (State or foreign country) SHARON PENNA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JOHN A. BRINKER				14. MOTHER'S MAIDEN NAME MARY POWERS					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT RITA E. BRINKER CUMBERLAND MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Fractures DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 2 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from roof of 2 story house							
20c. TIME OF INJURY Month, Day, Year Hour 2:30 p.m. July 24 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fell from Roof		20f. (City or town) (County) (State) Cumberland, Alleg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED July 24, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 27 1967		23c. NAME OF CEMETERY OR CREMATORY ST. MARYS CEMETERY		23d. LOCATION (City, town or county) (State) CUMBERLAND MARYLAND			
24. FUNERAL DIRECTOR <i>Louis Stein Inc.</i>		ADDRESS CUMBERLAND MD.		25a. REC'D BY REG. STRAR AUG 1 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03895

08896

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 44 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL-CUMB., MD.	
d. STREET ADDRESS 806 MICHIGAN AVE., CUMB., MD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) MABEL Beatrice BROWNING		4. DATE OF DEATH Month JULY Day 24 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG., 9, 1900
9. AGE (In years birthday) yrs 66		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWF.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND-ALLEGANY-MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN MILLESON		14. MOTHER'S MAIDEN NAME SALLY (HAINES)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 705-09-6677	
17. INFORMANT PT'S HOSPITAL CHART-SACRED HEART HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 443X DUE TO Embolism (b) Myocardial Infarction DUE TO Coronary Artery Disease (c) Cholelithiasis		INTERVAL BETWEEN ONSET AND DEATH 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. pm 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 19, 1967 to July 24, 1967 , that (I) (we) last saw the deceased alive on July 24, 1967 , and that death occurred at M , from causes and on the date stated above			
22a. SIGNATURE Blane M. Schindler		22b. DATE SIGNED July 25, 1967	
22c. PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.		22d. ADDRESS 43 GREENE ST., CUMB., KMD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/26/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR SILCOX FUNERAL HOME H. Lee Silcox		25a. REC'D BY REGISTRAR DATE JUL 27 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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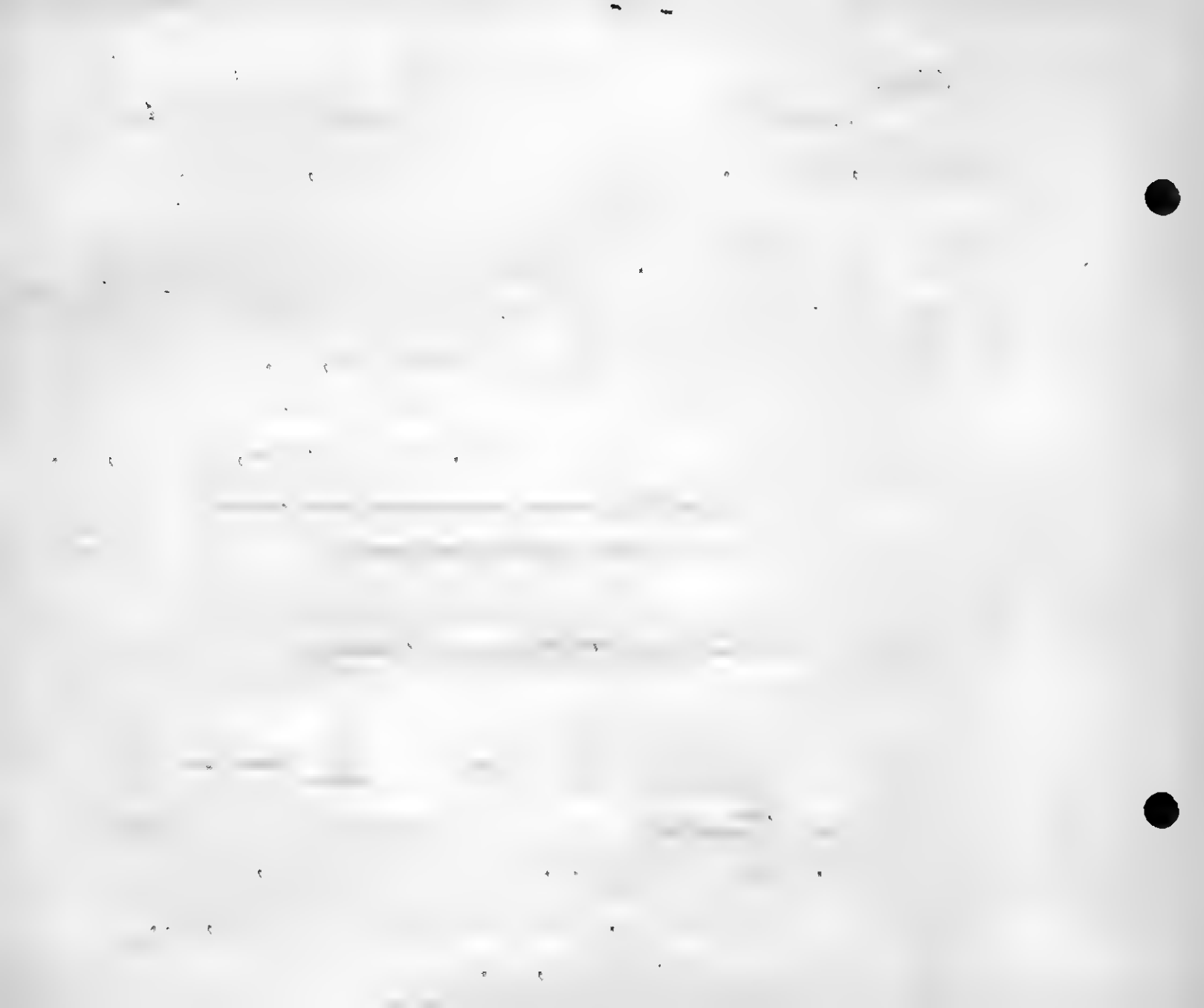
CERTIFICATE OF DEATH

08898

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Rural Rt. # 1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Rural Rt. # 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) RAYMOND H. BUCKALEW		4. DATE OF DEATH Month 7 Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/7/1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 64 yrs
11. BIRTHPLACE (County & State, or foreign country) Midlothian, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Buckalew		14. MOTHER'S MAIDEN NAME Grace Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Mary Buckalew, Midland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 331X IMMEDIATE CAUSE (a) Acute cerebrovascular accident DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(WIFE) INTERVAL BETWEEN ONSET AND DEATH Instant Death	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic obstructive pulmonary disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 15, 1966 to July 20, 1967 that (I) (we) last saw the deceased alive on July 21, 1967 , and that death occurred at 10:55 AM , from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED July 28, 1967	
22c. PHYSICIAN'S NAME (Type) A. Paige Strong M.D.		22d. ADDRESS Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/31/1967	23c. NAME OF CEMETERY OR CREMATORY St. Josephs Cemetery	23d. LOCATION (City or Town) (County) (State) Midland, Md.
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
ADDRESS Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 7 days after death.



CERTIFICATE OF DEATH

08898

08897

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 19 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS MT. SAVAGE	
3. NAME OF DECEASED (Type or print) First Middle Last EVA GLENDORA BURCH		4. DATE OF DEATH Month Day Year JULY 18, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 22, 1905
9. AGE (In years lost birthday) yrs 62		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHELL DEPT.		10b. KIND OF BUSINESS OR INDUSTRY KELLY-S. TIRE CO.	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD UHL		14. MOTHER'S MAIDEN NAME ALICE HOLTZMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-22-3402	
17. INFORMANT CHARLES BURCH, MT. SAVAGE, MD.		Address BOX 443	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 29, 1967 to July 18, 1967 , that (I) (we) lost saw the deceased alive on July 18, 1967 , and that death occurred at 3:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED 7/18/67	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JULY 20, 1967	23c. NAME OF CEMETERY OR CREMATORY METHODIST CEMETERY	23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR JUL 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Health Officer. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH

VR AISME
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08899 08898

1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b 62 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 506 Pennsylvania Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
e. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. STREET ADDRESS 506 Pennsylvania Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last
Harry Franklin Cage
4. DATE OF DEATH Month Day Year
July 26 19 67

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH
Oct. 15, 1904 9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor 10b. KIND OF BUSINESS OR INDUSTRY Railroad 11. BIRTHPLACE (State or foreign country) Cumberland, Md. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Cage 14. MOTHER'S MAIDEN NAME Anna V. Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Address
Mrs. Pearl Cage, Cumberland, Md. - wife

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion
Coronary Sclerosis
Conditions, if any, which gave rise to immediate cause (b) +
(c), stating the underlying cause lost. (c) +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) +

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month Day, Year Hour a.m. p.m. 19 31 20d. INJURY OCCURRED White Not White at work ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarajic M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ EXAMINER'S NAME (Type) BENEDICT SKITARAJIC, M.D. Address (Street, city, town, or county) Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE HEREOF July 29, 1967 22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park 22d. LOCATION (City, town, or county) (State) Cumberland, Md. Allegany

23. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md. 24a. REC'D BY REGISTRAR JUL 31 1967 24b. REGISTRAR'S SIGNATURE Charles Judge

CERTIFICATE OF DEATH

08890

08899

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in lb 8 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 19 W. FIRST ST.	
3. NAME OF DECEASED (Type or print) LESSIE A CAMPBELL		4. DATE OF DEATH Month 7-10 Day 19 Year 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-94
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (Country & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME RALIEGH PITZER		14. MOTHER'S MAIDEN NAME ZEDA MARTIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-38-0252	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 4221 IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO (b) cerebral Thrombosis DUE TO (c) Arteriosclerotic card. vas. Disease		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/14/67 , 19 8:30 P.M. , 19 67 , that (I) (we) last saw the deceased alive on 7/10 , 19 67 , and that death occurred at 7:14 M, from causes and on the date stated above.			
22a. SIGNATURE D. C. Dross M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. D. C. DROSS		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR JUL 14 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08901

08900

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

51 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Near Cumberland-La Vale

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

609 Greene St.

d. STREET ADDRESS

27 National Highway

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

NAME OF DECEASED
(Type or print)

First

Middle

Last

Gertrude Claire Clancey

4. DATE OF DEATH

Month

Day

Year

July 26

19

67

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

July 11, 1916

9. AGE (in years last birthday)

51 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Clancey

14. MOTHER'S MAIDEN NAME

Lucy Reilley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

no

16. SOCIAL SECURITY NO. 17. INFORMANT

Address

Mr. John B. Clancey, Cumberland, Md. Brother

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Pulmonary Embolism

INTERVAL BETWEEN ONSET AND DEATH
Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

DUE TO

(c)

(origin deep vessels left leg)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Benedict Skitarelic

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☒

July 26, 1967

EXAMINER'S NAME (Type)

BENEDICT SKITARELIC, M.D.

Address (Street, city, town, or county)

Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

July 29, 1967

22c. NAME OF CEMETERY OR CREMATORY

St. Mary's Cemetery

22d. LOCATION (City, town, or county)

Cumberland, Md. Allegany

23. FUNERAL DIRECTOR

ADDRESS

James F. Scarpelli, Cumberland, Md.

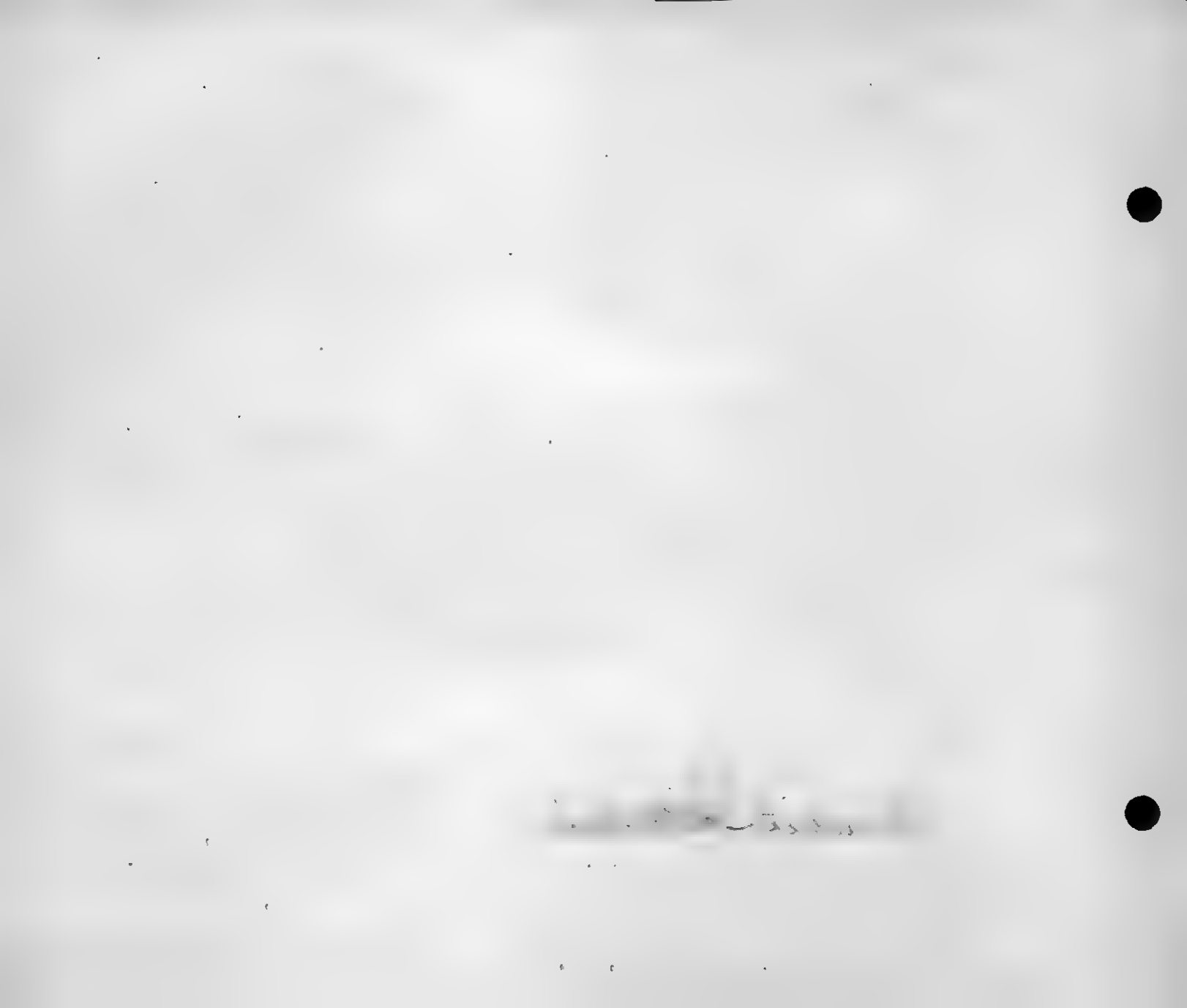
24a. REC'D BY REG. STRAR

24b. REGISTRAR'S SIGNATURE

JUL 31 1967

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any, is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08902

08901

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, RT. 2		c. LENGTH OF STAY IN It 5 MOS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		d. STREET ADDRESS GUNTER HOTEL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First: JAMES Middle: O. Last: CLARK		4. DATE OF DEATH Month: JULY Day: 5, Year: 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 29, 1894
9. AGE (In years) 73 yrs		10. IF UNDER 1 YEAR Months: Days: Hours: Min:	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED JANITOR		10b. KIND OF BUSINESS OR INDUSTRY LEGION BLDG.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN W. CLARK		14. MOTHER'S MAIDEN NAME ANNIE VAUGHAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO 212-18-1189	
17. INFORMANT ROY F. ATHEY, CUMBERLAND, MD. RT. 2, BOX 144		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) CORONARY SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED July 5, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JULY 8, 1967	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAEL'S CEMETERY	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR JUL 10 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08902

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. 1, CUMBERLAND, MD. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First FLOYD Middle G. Last CLITES (Type or print)		4. DATE OF DEATH Month JULY Day 25 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-22-97
9. AGE (In years lost ^{day} _{hrs}) 69		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1	11. IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES S. CLITES	
14. MOTHER'S MAIDEN NAME OLLIE LOGSDON		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 214--07-0216		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Left Lung with Bilateral Pulmonary Metastases - (Squamous Cell) DUE TO (b) Uncertain DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:05A p.m. 19 67	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from July 22, 1967 to July 25, 1967 , that (I) (we) last saw the deceased alive on July 24, 1967 , and that death occurred at 11:05A M, from causes and on the date stated above.	
22a. SIGNATURE Calvin Y. Hadzima		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. W. JAMES		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 28, 1967	
23c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		23d. LOCATION (City or Town) (County) (State) Hyndman, RD#1, Bedford Co., Pa.	
24. FUNERAL DIRECTOR Staraph H. Leigler ADDRESS Hyndman, PA.		25a. REC'D BY REGISTRAR JUL 31 1967 25b. REGISTRAR'S SIGNATURE Charles Jones	

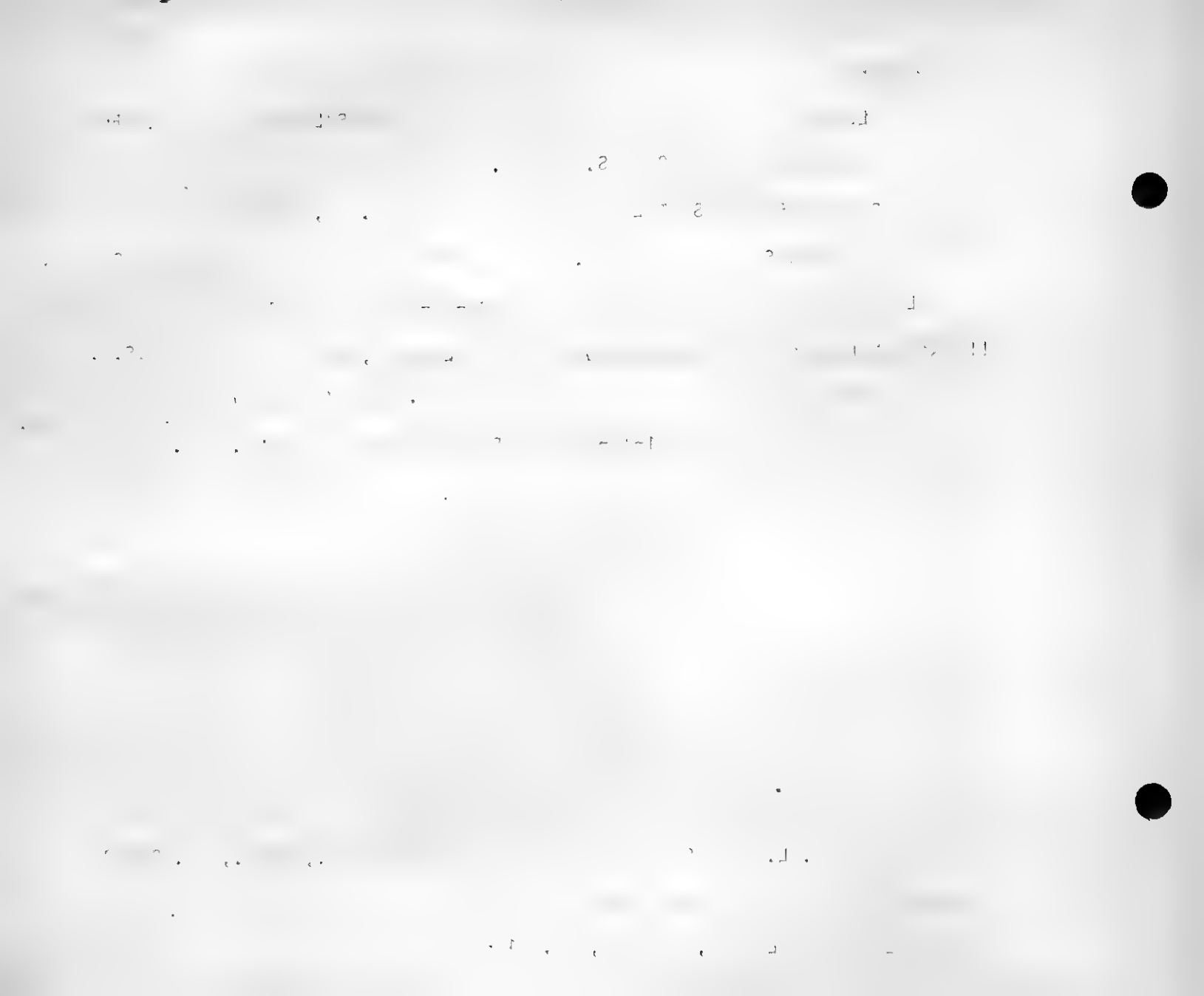
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



VR A15 (4)
2DM 1/65

1. PLACE OF DEATH a. COUNTY		ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE		PENNSYLVANIA		b. COUNTY		BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		CUMBERLAND		c. LENGTH OF STAY IN 1b		24 HRS. 45 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HYNDMAN		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		SACRED HEART HOSPITAL		d. STREET ADDRESS		RT. #1, BOX 75							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day Year	
CHARLES		W.		CONNER		7		27		19		67	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		04-04-86		81 yrs.		Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
OLLEDCROSSLINERS		FACTORY WORK		GLEN ROY, OHIO		U.S.A.							
13. FATHER'S NAME		JOHN CONNER		14. MOTHER'S MAIDEN NAME		MARGARET (EWING) CONNER							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		900 SETON DR.					
NO		281-14-6160		HOSPITAL RECORD		CUMB., MD. 21502							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> DUE TO <u>coronary sclerosis</u> DUE TO <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 days</u> <u>2 days</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>7-26</u> , 19 <u>67</u> , to <u>7-27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-27</u> , 19 <u>67</u> , and that death occurred at <u> </u> M., from the causes and on the date stated above.		22a. SIGNATURE <u>L. Brings</u>		22b. DATE SIGNED <u>7-28-67</u>		22c. PHYSICIAN'S NAME (Type) DR. L. BRINGS		22d. ADDRESS 57 GREENE ST., CUMB., MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
Burial		July 31, 1967		Porter Cemetery		Hyndman, PA. RD#1							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
ZEIGLER FUNERAL HOME, HYNDMAN, PA. 15545				JUL 31 1967		<u>Charles Judge</u>							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be filed as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/66

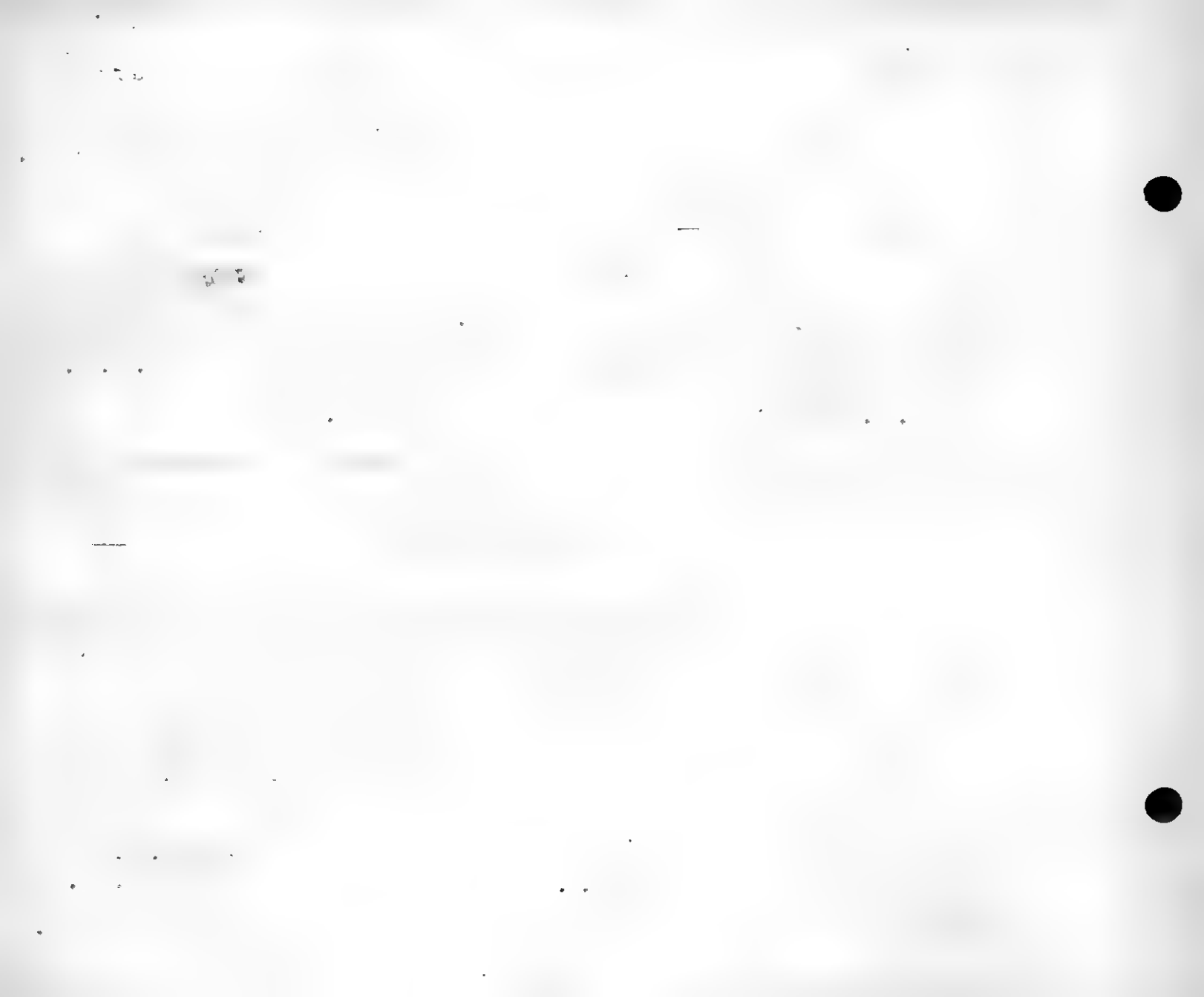
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08905

08904

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if inst. in Res. before adm. ssion) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowmans Addition		d. RURAL Cumberland Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital—DOA				d. STREET ADDRESS Bowmans Addition		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Harry Frederick Constable				4 DATE OF DEATH Month Day Year July 3 19 67			
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 26, 1899	9. AGE (In years lost birthday) yrs 67	10. UNDER 1 YEAR Months Days Hours Min 3 19 67		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Storage		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Cumberland Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME J. W. Constable				14. MOTHER'S MAIDEN NAME Minnie E. Allen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Bessie Constable		Address Bowmans Addition	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO CORONARY SCLEROSIS Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitabelic</i> M.D.				22. DATE SIGNED July 3, 1967			
EXAMINER'S NAME (Type) BENEDICT SKITABELIC, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR Louis Stein Inc. Cumberland Md.				25a. RECEIVED BY REGISTRAR JUL 6 1967 REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08906

08906

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland Md.</i>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <i>15 Forest Drive</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>15 Forest Drive</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Marie</i> Middle <i>A.</i> Last <i>Coyle</i>				4. DATE OF DEATH Month <i>July</i> Day <i>19</i> Year <i>1967</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 15, 1902</i>		9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Columbus Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A</i>
13. FATHER'S NAME <i>Thomas Shannon</i>				14. MOTHER'S MAIDEN NAME <i>Mary Cassidy</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mr. Bernard E. Coyle</i>		Address <i>Cumb Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> DUE TO (b) <i>Adeno Ca of hepatic duct</i> DUE TO (c) <i>—</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <i>Several Mo.</i> <i>less than 1 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 12, 1967</i> , to <i>July 12, 1967</i> , that (I) (we) last saw the deceased alive on <i>July 12, 1967</i> , and that death occurred at <i>115 So. Centre - Cumberland</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>A. J. Mirkin</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>7-20-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. J. MIRKIN</i>				22d. ADDRESS <i>115 So. Centre - Cumberland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/21/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Peter & Paul Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Cumberland Md.</i>	
24. FUNERAL DIRECTOR <i>Louis Stein Inc. Cumberland Md</i>				25a. REC'D BY REGISTRAR <i>—</i>		25b. REGISTRAR'S SIGNATURE <i>—</i>	

DATE *JUL 24 1967*

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CERTIFICATE OF DEATH

08907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 47 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND. 21502	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			e. STREET ADDRESS 907 3rd Avenue Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) SYLVIA (LEANNA) CROSBY			4. DATE OF DEATH Month JULY Day 26 Year 19 67		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-02		9. AGE (In years last birthday) yrs 65
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) Textile Wkr.		10b. KIND OF BUSINESS OR INDUSTRY Celanese Fibres		11. BIRTHPLACE (County & State or foreign country) MINERAL, KEYSER, W. VA.	
12. CITIZEN OF WHAT COUNTRY U.S.A.			13. FATHER'S NAME HENRY LICKENS		
14. MOTHER'S MAIDEN NAME LAURA A. KIGHT			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		
16. SOCIAL SECURITY NO. 214-05-6132			17. INFORMANT PATIENT HOSPITAL RECORD-SACRED HEART HOSP.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: 2040 IMMEDIATE CAUSE (a) Cerebral Haemorrhage DUE TO (b) Thrombocytopenia DUE TO (c) Leukemia - Lymphocytic, chronic					INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Embolism & Thrombophlebitis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above					
22a. SIGNATURE Clarence J. Vincent M.D.			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) CLARENCE J. VINCENT, M.D.			22d. ADDRESS 126 N. SMALLWOOD ST. CUMB., MD 21502		
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/29/67	23c. NAME OF CEMETERY OR CREMATORY Bayard Cemetery		23d. LOCATION (City or Town) _____ (County) _____ (State) _____ Bayard, Grant, W. Va.	
24. FUNERAL DIRECTOR H. Wayne George Cumb. Md.			25a. REC'D BY REGISTRAR DATE JUL 31 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes that proper record-keeping is essential for transparency and accountability, particularly in financial matters. The text notes that without reliable records, it is difficult to track progress, identify issues, and make informed decisions.

2. The second part of the document outlines the various methods and tools used to collect and analyze data. It mentions the use of surveys, interviews, and focus groups to gather qualitative information, as well as statistical analysis and data visualization techniques to process quantitative data. The document stresses the need for a systematic approach to data collection and analysis to ensure the validity and reliability of the findings.

3. The third part of the document describes the process of interpreting the results and drawing conclusions. It highlights the importance of comparing the findings with existing knowledge and theories to identify patterns and trends. The text also discusses the potential limitations of the study and the need for further research to address these limitations.

4. The final part of the document provides a summary of the key findings and offers recommendations for future actions. It concludes by emphasizing the value of the research in providing insights into the subject matter and the potential for applying these insights to improve practice and policy.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08907

08908

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 149 FROST AVENUE				d. STREET ADDRESS 149 FROST AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle E. Last DENNISON				4. DATE OF DEATH Month JULY Day 26 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 27, 1895		9. AGE (In years last birthday) yrs 72	IF UNDER 1 YEAR Months Days Hours Mm	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM GEARY				14. MOTHER'S MAIDEN NAME JANE POOLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 214-01-3660-B		17. INFORMANT ALLEN DENNISON, FROSTBURG, MD. Address 149 FROST AVE.,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular disease DUE TO (b) Arterio-sclerosis DUE TO (c) Heart Block.							INTERVAL BETWEEN ONSET AND DEATH —
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-10 , 19 63 , to 7-26 , 19 67 , that (I) (we) last saw the deceased alive on 7-26 , 19 67 , and that death occurred at 7 P. M, from causes and on the date stated above.							
22a. SIGNATURE H. C. Diehl				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/28/67	
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M. D.				22d. ADDRESS 39 W. MAIN ST., FROSTBURG, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 29 '67		23c. NAME OF CEMETERY OR CREMATORY FBG. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532				25a. REC'D BY REGISTRAR DATE JUL 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

CERTIFICATE OF DEATH

08909

08908

1. PLACE OF DEATH o COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if inst. tution. Residence before adm ssion) o STATE MARYLAND b. COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY in 1b 2WKS 2½ DAYS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d STREET ADDRESS 809 ASHBROOK AVENUE	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) RALPH First BOWIE Middle DOAK Last		4 DATE OF DEATH Month JULY Day 1 Year 67	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-1913
9 AGE (in years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WESTERN MD. R. R. (CHIEF CLERK)		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND
12 CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME HENDERSON H. DOAK		14 MOTHER'S MAIDEN NAME FRANCES LILLARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2		16. SOCIAL SECURITY NO. 215 26 6914	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Carcinoma of pancreas with DUE TO (b) metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1967 , to June 30, 1967 that (I) (we) lost saw the deceased alive on 6/30/1967 , and that death occurred at 4:47 P.M. from causes and on the date stated above.			
22a. SIGNATURE Thomas F. Lewis		22b. DATE SIGNED 7/1/67	
22c. PHYSICIAN'S NAME (Type) DR. THOMAS F. LEWIS		22d. ADDRESS 500 GREENE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JULY 3, 1967	23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR BYRON KIGHT CUMBERLAND, MD.		25a. REC'D BY REGISTRAR JUL 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY ALLEGANY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.					c. LENGTH OF STAY IN ID 15 DAYS				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL					d. STREET ADDRESS P.O. BOX 12, 546 A ST.				
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH C. DRESSMAN					4. DATE OF DEATH Month Day Year 7 12 19 67				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-5---05		9. AGE (In years last birthday) 61 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ECKHART ALLEGANY CO. - MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN MILKOSKI					14. MOTHER'S MAIDEN NAME EMMA MARCZYNSKI				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-20-6168		17. INFORMANT HOSPITAL			Address SETON DRIVE CUMBERLAND, MD. 21502		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary failure DUE TO (b) Coronary atherosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE Charles T. Jones						22b. DATE SIGNED JUL 17 1967			
22c. PHYSICIAN'S NAME (Type) DR. M. GLICK & DR. W. SPIGGLE						22d. ADDRESS 126 N. SMALLWOOD ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 7/14/67		23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul			23d. LOCATION (City, town or county) (State) Cumberland Md.		
24. FUNERAL DIRECTOR Louis Stein Inc						25a. REC'D BY REGISTRAR JUL 17 1967			
ADDRESS Cumb Md.						25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

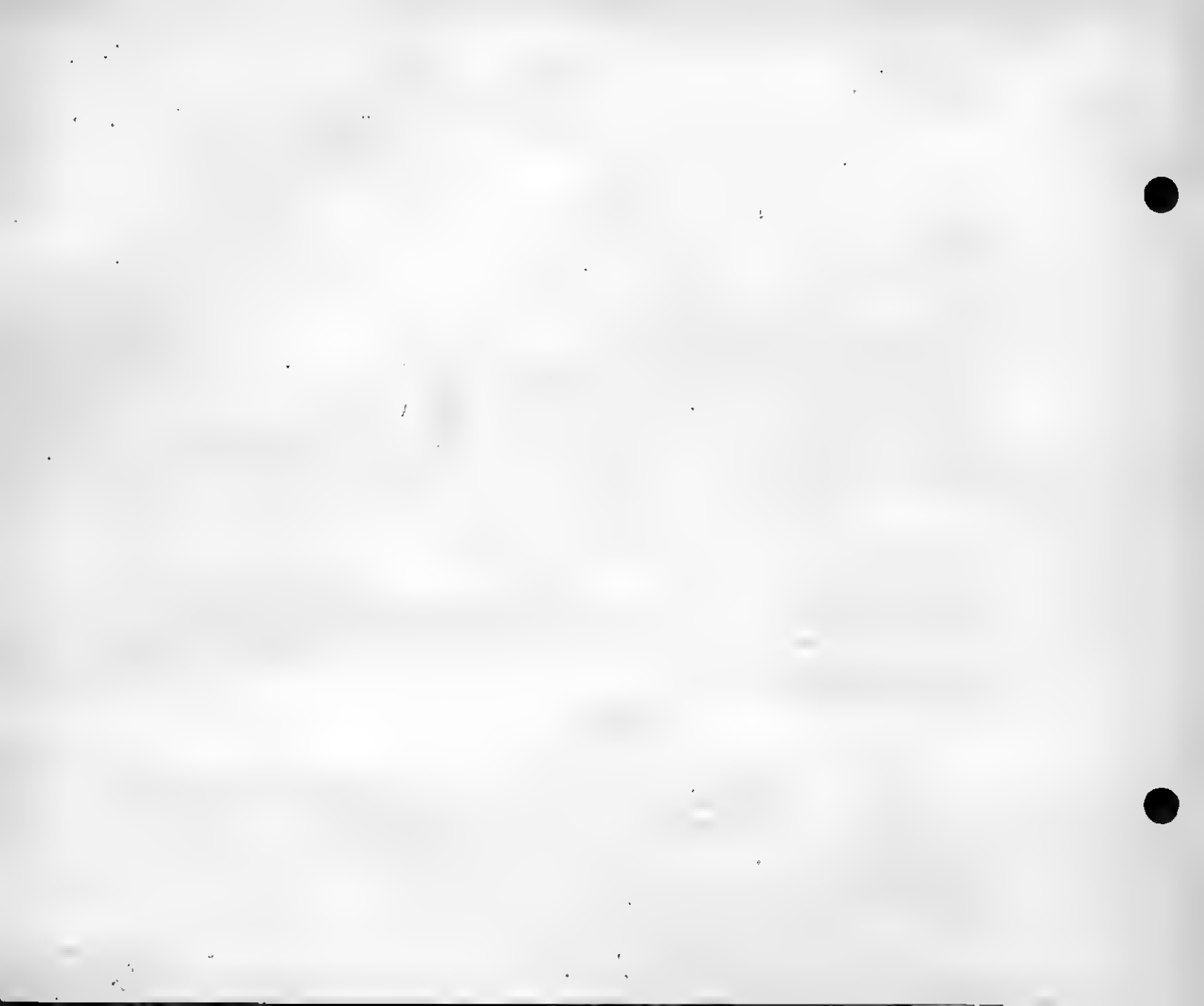
08910

08911

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 200 SETON DRIVE 546 A St.	
3. NAME OF DECEASED (Type or print) GEORGE First Middle Last A. DRESSMAN		4. DATE OF DEATH Month 7- Day 18- Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-96
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POST OFFICE WORKER		10b. KIND OF BUSINESS OR INDUSTRY POSTAL	9. AGE (In years last birthday) 71 yrs
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH Dressman		14. MOTHER'S MAIDEN NAME MARY (DETERMAN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO 218-30-0709	
17. INFORMANT HOSPITAL RECORD, 200 SETON DRIVE, CUMB., MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO (b) Arterio-sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Depression			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 17, 1967 , to July 18, 1967 , that (I) (we) last saw the deceased alive on July 18, 1967 , and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Clarence J. Vincent		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Clarence Vincent		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/20/67	23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem. Cumb. MD	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR STEINS FUNERAL HOME, 117 FREDERICK STREET CUMB., MD. 21502		25a. REC'D BY REGISTRAR JUL 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in only event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08912

08911

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write "Rural") LaVale		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale 011	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 19 Glenview Terrace		e STREET ADDRESS 19 Glenview Terrace	
3 NAME OF DECEASED (Type or print) Julian Cline Driver		4 DATE OF DEATH July 26, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 22, 1902
9 AGE (In years lost birthday) 64 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher (Ret.)		10b KIND OF BUSINESS OR INDUSTRY Transit Co.	
11 BIRTHPLACE (State or foreign country) New Market, Va.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Dorilas J. Driver		14 MOTHER'S MAIDEN NAME Barbara Rosenberger	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 241-10-5553	
17 INFORMANT Mr. J. Wayne Driver		Address Fairfax, Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ----- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Rt. # 9 Cumberland, Md.	
23a BURIAL CREMATORY, REMOVAL (specify) Burial	23b DATE THEREOF 7/29/67	23c NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24 FUNERAL DIRECTOR H. Wayne George		25a REG'D BY REGISTRAR JUL 31 1967 25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

08913

Item 10a, Film G390 7/21/67 cac

08912

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 3 WKS. 1 DAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 144 WOOD STREET	
3 NAME OF DECEASED (Type or print) ROBERT D. EWING		4. DATE OF DEATH Month JULY Day 8 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) RETIRED ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY BUREAU OF MINES	9. AGE (In years last birthday) 69 yrs
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN EWING		14. MOTHER'S MAIDEN NAME DELLA JONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-24-8364	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal and Cerebrovascular 7111 DUE TO Art Sch Chd. e. Plurim Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO 3 weeks (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 6/16/67 , 19____, to 7/8/67 , 19____ that (I) (we) last saw the deceased alive on 7/8/67 , 19____, and that death occurred on 7/11/67 from causes and on the date stated above.		20f. City or town (County) (State) Cumby Falls, MD	
22a. SIGNATURE DR. R.J. WILLIAMS		22b. DATE SIGNED 7/11/67	
22c. PHYSICIAN'S NAME (Type) DR. R.J. WILLIAMS		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 12 '67	
23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR JUL 13 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08914 CERTIFICATE OF DEATH 08912									
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 7 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 50 GREENE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARGARET ANN FRAME			4. DATE OF DEATH Month JULY Day 7 Year 19 67						
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03/22/92		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) BRARTON CO., W. VA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME TIMOTHY COOK				14. MOTHER'S MAIDEN NAME Evelyn BISHOP					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. X NONE - XXX		17. INFORMANT HOSPITAL RECORD		Address SACRED HEART HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Failure of Circulation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Failure of coronary artery DUE TO (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Failure of Circulation INTERVAL BETWEEN ONSET AND DEATH 1 week									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from January , 19 65 , to July 7 , 19 67 , that (I) (we) last saw the deceased alive on July 7 , 19 67 , and that death occurred at 7 M, from the causes and on the date stated above.									
22a. SIGNATURE Blaine Schindler					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 7/67		
22c. PHYSICIAN'S NAME (Type) Blaine Schindler, M.D.					22d. ADDRESS 43 Greene St. Cumb. Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/11/67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland, Allegany, Md.			
24. FUNERAL DIRECTOR H. Wayne George					25a. REC'D BY REGISTRAR (Type) REGISTRAR'S SIGNATURE John H. George DATE JUL 12 1967				

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CERTIFICATE OF DEATH

08914

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

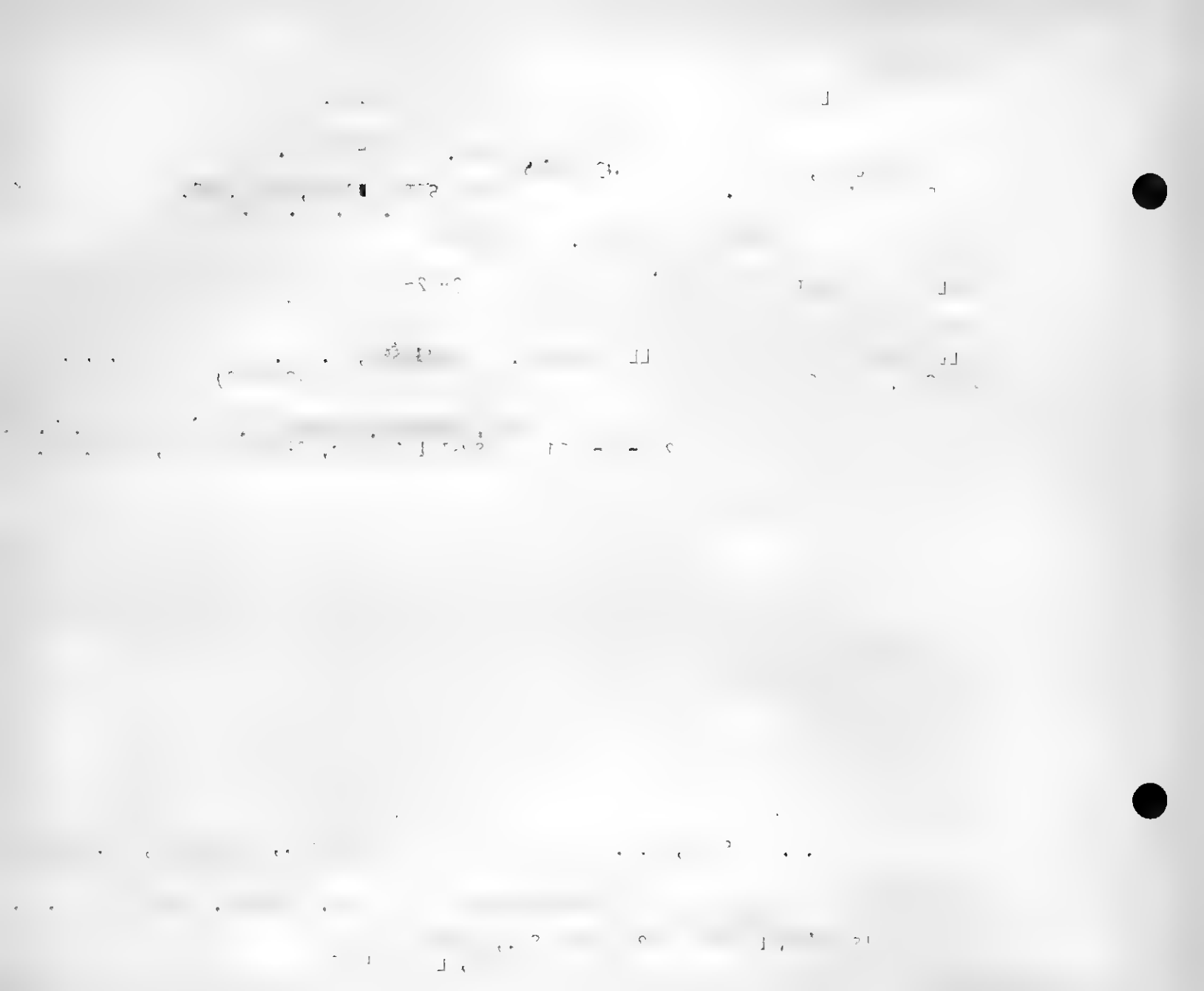
1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Midland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ANNA First Middle Last G. GOODRICH		4. DATE OF DEATH 7/13/1967 Month Day Year 19	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1880
9 AGE (In years last birthday) 87 yrs		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Mt. Savage, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Steele		14. MOTHER'S MAIDEN NAME Helena Hahn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Herman Kamauff		Address Lonaconing, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic evd (SON) 4201 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 25 yrs	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/20, 1967 to 7/13, 1967 , that (I) (we) last saw the deceased alive on 7/13, 1967 , and that death occurred at 6:50 AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Martin Rothstein</i>		22b. DATE SIGNED 7/14/67	
22c. PHYSICIAN'S NAME (Type) Martin Rothstein		22d. ADDRESS Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/16/1967	
23c. NAME OF CEMETERY OR CREMATORY German Lutheran		23d. LOCATION (City or Town) (County) (State) Frostburg, Md.	
24. FUNERAL DIRECTOR George Eichhorn		25a. REC'D BY REGISTRAR JUL 17 1967	
ADDRESS Lonaconing, Md.		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY ALLEGANY						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. VA. b. COUNTY MINERAL					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RIDGELEY Rt. # 1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSP.						e. STREET ADDRESS 300 SETON ST. Along W. Va. St. Rt. 28					
3. NAME OF DECEASED (Type or print) First: HIETT Middle: McKinley Last: GRAPES						4. DATE OF DEATH Month 7 Day 3 Year 1967					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-12-97		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILL WRIGHT				10b. KIND OF BUSINESS OR INDUSTRY KELLY TIRE CO.		11. BIRTHPLACE (County & State, or foreign country) Augusta, W. VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES E. GRAPES						14. MOTHER'S MAIDEN NAME VIRGINIA (SOWERS)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO						16. SOCIAL SECURITY NO. 217-10-6631					
17. INFORMANT Mrs. Hiett M. Grapes Rt. # 1 Ridgeley, W. Va.						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 113 DUE TO (b) Renal Failure DUE TO (c) Myocardial Infarction - arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Fibrosis Cerebral arteriosclerosis					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to 7/3 , 19 67 , that (I) (we) last saw the deceased alive on 7/3 19 67 , and that death occurred 8:15 PM , from the causes and on the date stated above.											
22a. SIGNATURE S. G. Weisman						22b. DATE SIGNED 7/5/67					
22c. PHYSICIAN'S NAME (Type) S. G. WEISMAN, M.D.						22d. ADDRESS 59 GREENE ST., CUMBERLAND, MD. 21502					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/7/67		23c. NAME OF CEMETERY OR CREMATORY Pleasantdale Cemetery				23d. LOCATION (City, town or county) (State) nr. Augusta, Hampshire, W. Va.	
24. FUNERAL DIRECTOR GEORGE'S FUNERAL HOME						25a. REC'D BY REGISTRAR H. Wayne George					
25b. REGISTRAR'S SIGNATURE 202 GREENE ST., CUMB						DATE JUL 10 1967 MARYLAND 21502					



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 410 Louisiana Avenue	
3. NAME OF DECEASED (Type or print) First Anna Middle Margaret Last Heberle		4. DATE OF DEATH Month July Day 18 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/18/1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 66 yrs.
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Emil Rokos		14. MOTHER'S MAIDEN NAME Maria ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 341-07-1855	
17. INFORMANT Carl Heberle, 410 Louisiana Ave., Cumberland		Address Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Myocardial Infarction DUE TO (b) Coronary Occlusion DUE TO (c) Coronary Sclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 Hours 2 Hours ----
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		22. DATE SIGNED July 18, 1967	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/22/67	23c. NAME OF CEMETERY OR CREMATORY St. Adalberts Cemetery	23d. LOCATION (City, town or county) (State) Niles, Ill.
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR JUL 21 1967	
Address John J. Hafer, Jr., 230 Balto Ave., Cumberland, Md		25b. REGISTRAR'S SIGNATURE Charles J. J...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

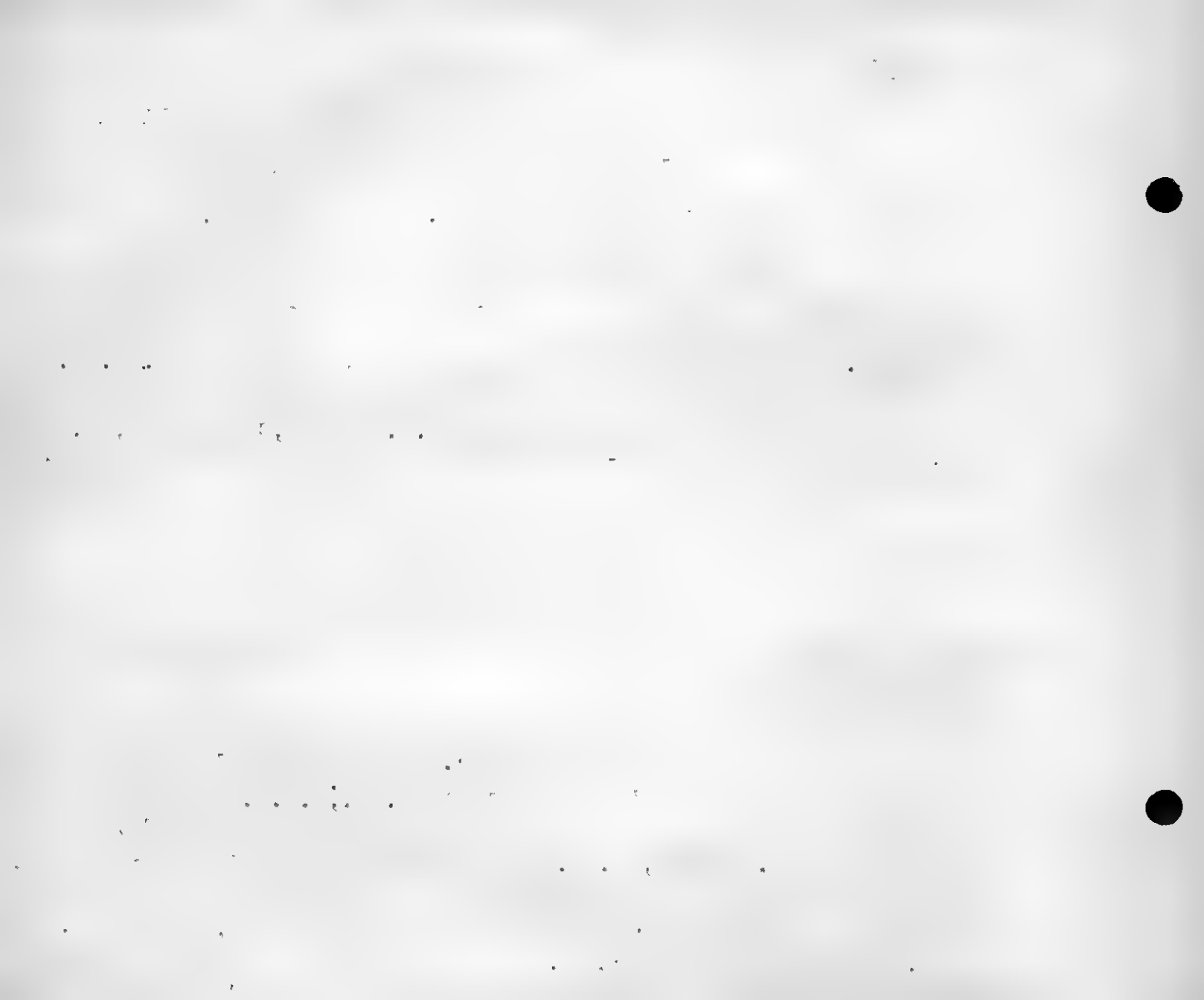
MARYLAND STATE DEPARTMENT OF HEALTH

08918

CERTIFICATE OF DEATH

08917

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Res dence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/23/1961	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS Rt. # 5 Winchester Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frank Middle John Last Helbig		4. DATE OF DEATH Month July Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/19/1884
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Worker		10b. KIND OF BUSINESS OR INDUSTRY Switchman	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Helbig		14. MOTHER'S MAIDEN NAME Bridget Honaghan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NR		16. SOCIAL SECURITY NO 705-07-9552	
17. INFORMANT P.O. Box 599, Cumberland, Md. 21502		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute cerebral hemorrhage 1913 DUE TO (b) Carcinoma, Rt. Chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Metastatic carcinoma of brain 14 yrs. 8 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A.S. Chronic R.H.D. with Chr. Myocarditis and insufficiency			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec. 23, 19 61 to July 17, 19 67 , that (I) (we) last saw the deceased alive on July 15, 19 67 , and that death occurred at A. M. from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED 7/17/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/20/67	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



08919

CERTIFICATE OF DEATH

08910

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 HRS. 10 MIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS 727 SYLVAN AVE.	
3. NAME OF DECEASED (Type or print) First HUNTER Middle B. Last HELFRICH		4. DATE OF DEATH Month JULY Day 1 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-1886
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired General Contractor		10b. KIND OF BUSINESS OR INDUSTRY Allegany Co Maryland	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN HELFRICH		14. MOTHER'S MAIDEN NAME LAURA JUDY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-05-7230	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Coronary Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 7/1/67 , 19 67 , to 7/1/67 , 19 67 , that (I) (we) last saw the deceased alive on 7/1/67 , 19 67 , and that death occurred at 4:45 PM from causes and on the date stated above. 22a. SIGNATURE RICHARD J. WILLIAMS, M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) 22b. DATE SIGNED 7/2/67 22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/4/67	
23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox Cumberland, Maryland 21502		25a. REC'D BY REGISTRAR DATE JUL 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

38920

38919

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 21 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 40-4 Miles East Cumberland, Md.		e. STREET ADDRESS 1008 Oldtown Road	
3 NAME OF DECEASED (Type or print) Dennis Roger Helmick		4 DATE OF DEATH Month July Day 22 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 8, 1946
9 AGE (In years lost birthday) yrs 21		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b KIND OF BUSINESS OR INDUSTRY Railroad	
11 BIRTHPLACE (State or foreign country) Cumberland, Md.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Foster S. Helmick		14 MOTHER'S MAIDEN NAME Twyla Broll	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO no	
17 INFORMANT Foster S. Helmick, Cumberland, Md. Father		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax, bilateral DUE TO Crushed Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severed Spine DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes Sudden Sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger on single motorcycle accident	
20c TIME OF INJURY Month, Day, Year Hour 6:20 pm July 22 19 67	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Rt. #40, 4 miles East, Cumberland, Alleg. Md.	20f (City or town) (County) (State) Cumberland, Md.
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		22. DATE SIGNED July 22, 1967	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		Address (Street, city, town, or county) Cumberland, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF July 25, 1967	23c NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	23d LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany
24 FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a REC'D BY REGISTRAR JUL 26 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08921

CERTIFICATE OF DEATH

08920

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) a STATE MARYLAND b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c LENGTH OF STAY IN lb 6 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 331 DAVIDSON ST.,	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle G. Last HUMBERTSON		4. DATE OF DEATH Month JULY Day 22 Year 19 67.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-19-1899
9. AGE (In years last birthday) yrs 68		IF UNDER 1 YEAR Months 0 Days 22 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10b. KIND OF BUSINESS OR INDUSTRY HOUSE PAINTER	
11. BIRTHPLACE (County & State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME YAGLE HUMBERTSON		14. MOTHER'S MAIDEN NAME BELLE BOGGS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 217 10 7617A	
17. INFORMATION MEMORIAL HOSPITAL -		Address CUMBERLAND, MD.	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease DUE TO (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 19, 1967 to July 22, 1967 that (I) (we) last saw the deceased alive on July 22, 1967 and that death occurred at 8:20 A.M. from heart disease and on the date stated above			
22a. SIGNATURE Dr. Blane Schindler		22b. DATE SIGNED 7/23/67	
22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER		22d. ADDRESS 43 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JULY 25, 1967	23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK	23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR JUL 31 1967	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rt. #1 Frostburg, Md.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HIGHWAY # 36		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) RICHARD	First A. Middle HUNT Last	4. DATE OF DEATH 7/2/1967	Month 7 Day 2 Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/1950
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student (Beall High School)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 17 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard W. Hunt		14. MOTHER'S MAIDEN NAME Thelma Ringer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Richard W. Hunt (Rural) Frostburg, Md. (Father)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock; Exanguination DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severed left leg; compression of chest DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of single car accident	
20c. TIME OF INJURY Month, Day, Year 10:00 - JUNE 7-2-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt #36 - 2 Mi. north, Midland, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DATE SIGNED July 2, 1967 Address (Street, city, town, or county) Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/5/1967	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR GEORGE EICHHORN		24a. REC'D BY REGISTRAR JUL 5 1967 24b. REGISTRAR'S SIGNATURE Charles Judge	

1 FOR STATE HEALTH DEPT. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08922 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08922

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Prairie	
c. LENGTH OF STAY in 1b 3 Hours		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital			
3. NAME OF DECEASED (Type or print) GEORGE R. HUSK		4. DATE OF DEATH July 8th. 1967 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14th. 1914 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME James Husk		14. MOTHER'S MAIDEN NAME Susan Parker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Easter Husk Address East Prairie, Missouri	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion			
DUE TO Coronary Sclerosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF 7/11/1967		DATE SIGNED 7/8/1967	
22c. NAME OF CEMETERY OR CREMATORY East Prairie, Missouri		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR George Eichhorn, Lonaconing, Md.		24a. REC'D BY REGISTRAR JUL 11 1967 24b. REGISTRAR'S SIGNATURE	

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123456789



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08923

08924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. STREET ADDRESS ROUTE #2	
3 NAME OF DECEASED (Type or print) ROBERT PATTERSON JAY		4. DATE OF DEATH Month JULY Day 20 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/11/90
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (County & State, or foreign country) ARTEMAS, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL		14. MOTHER'S MAIDEN NAME AGNES (BARKMAN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 196-22-0061	
17. INFORMANT HOSPITAL RECORD		Address SACRED HEART HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Pulmonary Embolus 11X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Status Asthmaticus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema			INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-10 , 19 67 , to 7-20 , 19 67 , that (I) (we) last saw the deceased alive on 7-18 , 19 67 , and that death occurred at 7-20 M, from causes on and on the date stated above.			
22a. SIGNATURE W. C. Spiggle		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7-22-67
22c. PHYSICIAN'S NAME (Type) W. C. SPIGGLE, M. D.		22d. ADDRESS 126 N. SMALLWOOD, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JULY 23, 1967	23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CHRIST. CHURCH	23d. LOCATION (City or Town) (County) (State) ARTEMAS, PENNA.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD. 21532		25a. REC'D BY REGISTRAR JUL 25 1967	
		25b. REGISTRAR'S SIGNATURE Juanita Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

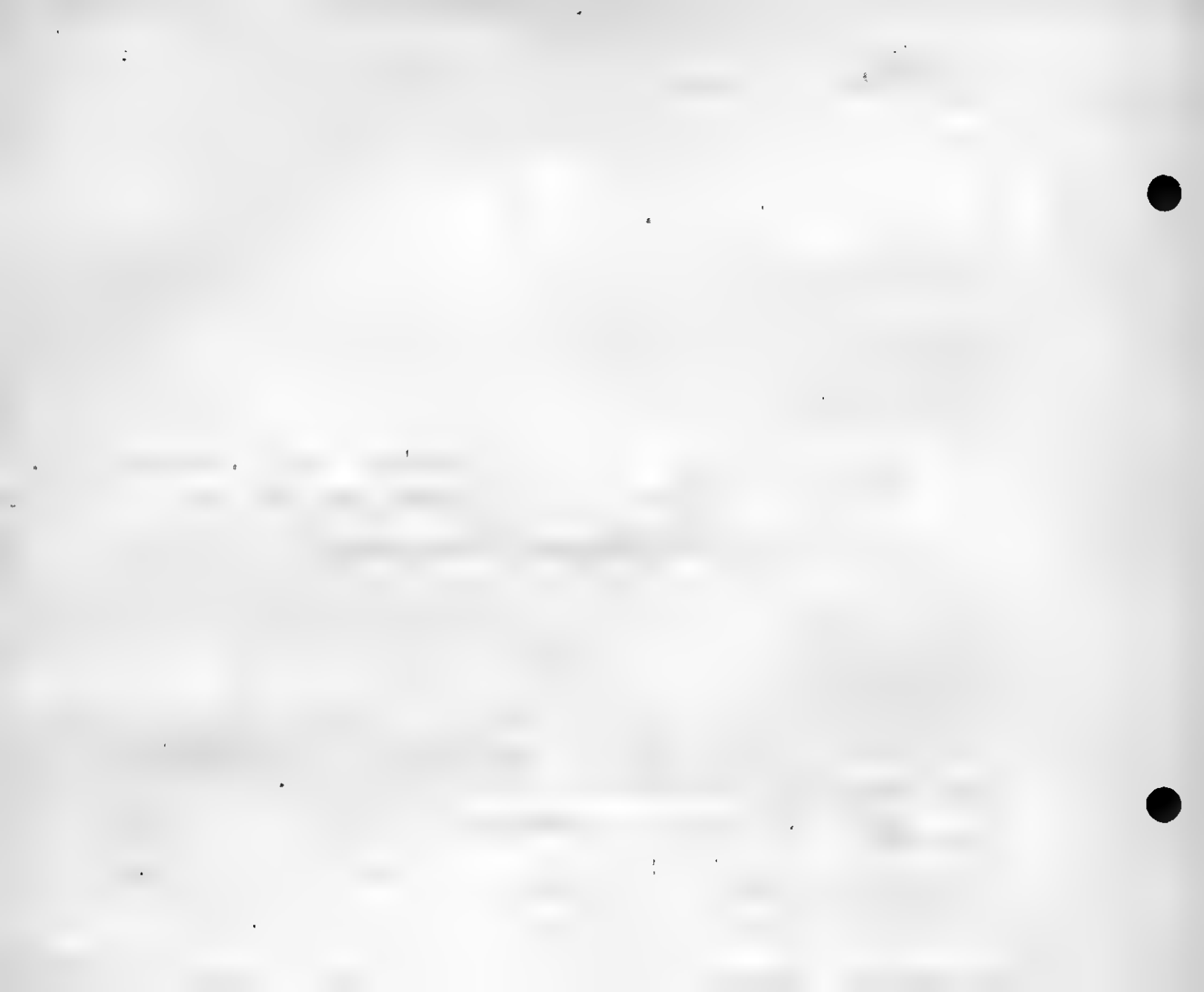
MARYLAND STATE DEPARTMENT OF HEALTH

08925

CERTIFICATE OF DEATH

08924

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 1/2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 1314 FREDERICK STREET	
3. NAME OF DECEASED (Type or print) WILLIAM JOHNSON		4. DATE OF DEATH JULY 22, 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1873
9. AGE (In years last birthday) yrs. 94		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY DAIRY AND INSURANCE	
11. BIRTHPLACE (County & State, or foreign country) SOMERSET, PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME REUBEN JOHNSON		14. MOTHER'S MAIDEN NAME MARY PINKERTON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 300 01 9339 A	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446x DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (c)		INTERVA. BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> NOT While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/12/67, 19 to 7/22/67, 19, that (I) (we) last saw the deceased alive on 7/21/67, 19, and that death occurred at 4:35 M. from causes and on the date stated above.		22a. SIGNATURE DR. R. J. WILLIAMS	
22b. DATE SIGNED 7/24/67		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS 122 SO. CENTRE ST. CUMBERLAND, MD.		22e. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 25, 1967	
23c. NAME OF CEMETERY OR CREMATORY ST. LUKES CEMETERY		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REGD BY REGISTRAR DATE JUL 31 1967	



1
FBI STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

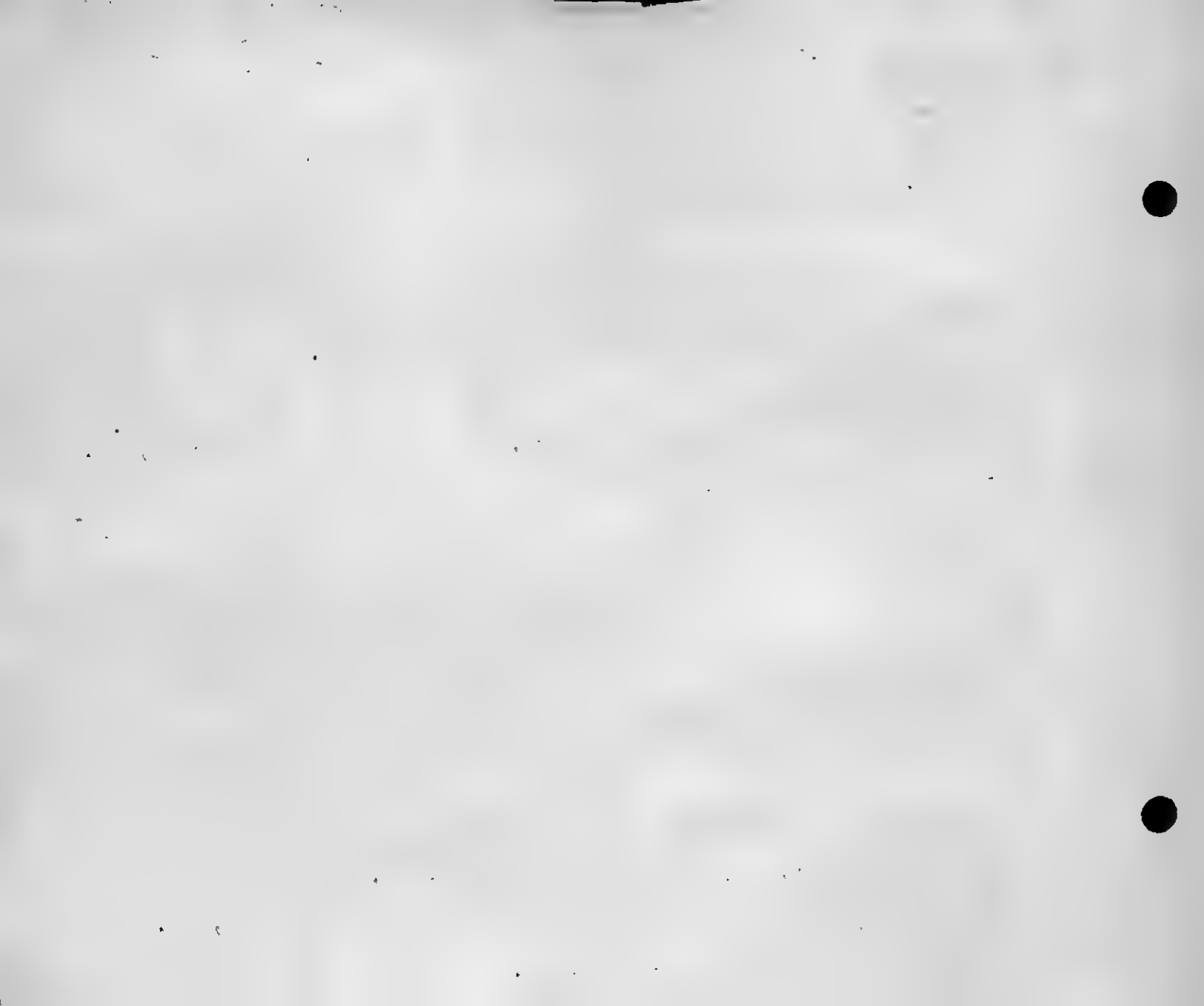
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08926

08925

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 35 Rye Street		2. USUAL RESIDENCE (Where deceased lived, if not last one; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg d. STREET ADDRESS 156 Bowary Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AURELIA First Middle Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH 7/4/1967 Month Day Year 8. AGE (In years last birthday) 83 yrs. 9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Lonaconing MD. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Lyons 14. MOTHER'S MAIDEN NAME Mary Stewart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) No (If yes give year or dates of service) 16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs. Virgie Jones		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary-Occlusion 42.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) Benedict Skitarelic Cumberland, Md. DATE SIGNED 7/4/1967			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/6/1967 22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery 22d. LOCATION (City, town, or country) (State) Lonaconing, Md.		23. FUNERAL DIRECTOR GEORGE EICHHORN Lonaconing, Md. 24a. REC'D BY REGISTRAR JUL 6 1967 24b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION



08926

CERTIFICATE OF DEATH

08927

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 3 Years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 210 Harrison Street		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS 210 Harrison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles E. Jones		4. DATE OF DEATH Month July Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 7, 1907
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min 59	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile Worker- Celanese Corp of America		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry James Jones		14. MOTHER'S MAIDEN NAME Minnie Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-07-5518	
17. INFORMANT Mrs. Cecile Jones		Address 210 Harrison St Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept , 1966, to 30 July , 1967, that (I) (we) last saw the deceased alive on 29 June 1967 , and that death occurred at 2:41 M, from causes and on the date stated above.			
22a. SIGNATURE L. Michael Glick		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) L. Michael Glick		22d. ADDRESS 126 N. Smallwood St. Cumberland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 7/6/67	23c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Maryland
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR DATE JUL 10 1967	
ADDRESS Cumberland, Maryland 21502		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 18, Film 641 8 15/61 cag

38928

08927

1. PLACE OF DEATH
a. COUNTY

Allegany

b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN

Minutes

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sacred Heart Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

Coronary Sclerosis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

INTERVAL BETWEEN ONSET AND DEATH

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE

Benedict Skitarelic

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

July 31, 1967

EXAMINER'S NAME (Type)

Benedict Skitarelic, M.D.

Address (Street, city, town, or county)

Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Kath Newman

Grantsville, Md.

AUG 3 1967

Charles Judge

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, the certificate should be executed within 72 hours after death. If an autopsy is not necessary, the certificate should be executed within 72 hours after death. If an autopsy is necessary, the certificate should be executed within 72 hours after death. If an autopsy is not necessary, the certificate should be executed within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08928

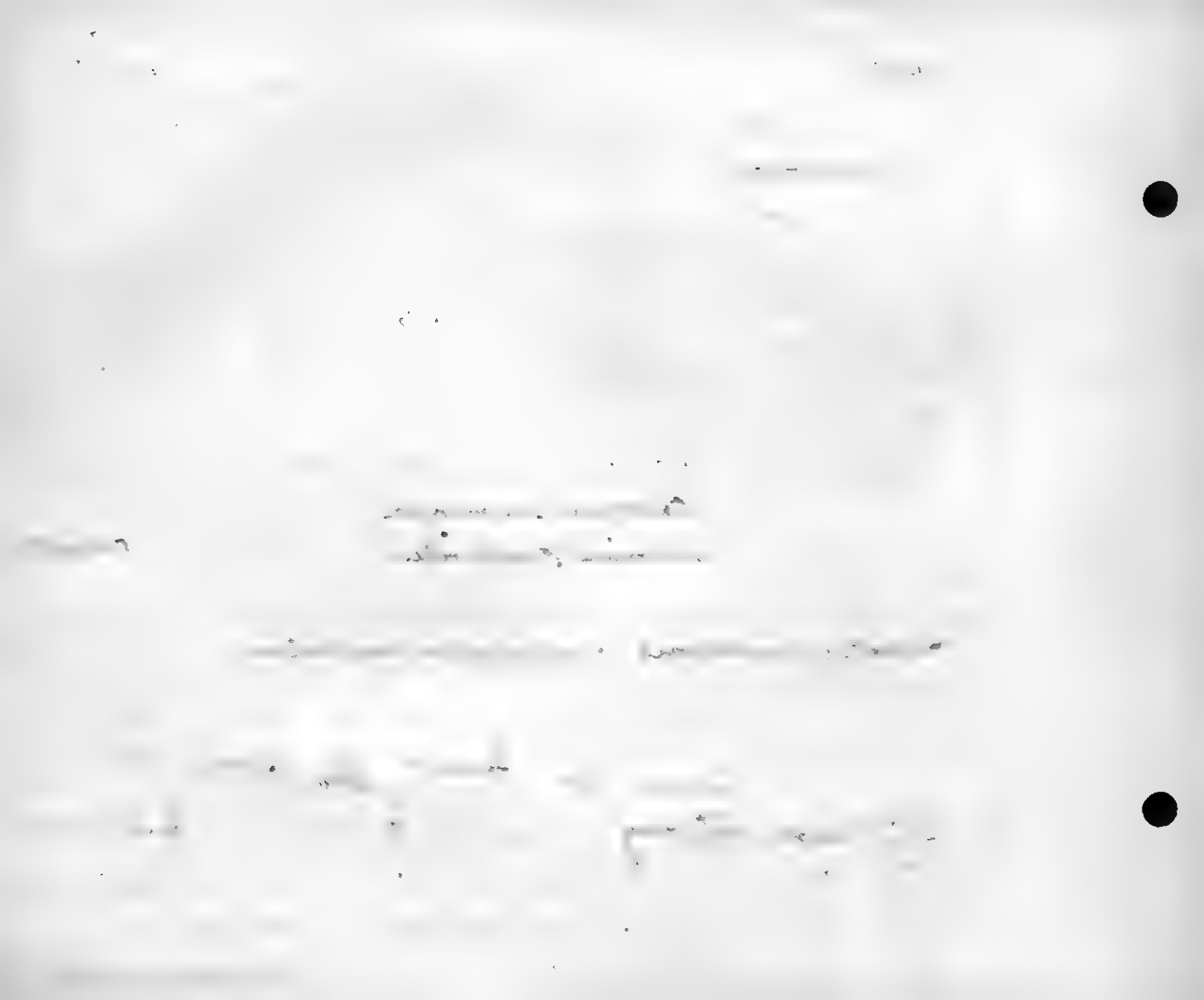
CERTIFICATE OF DEATH

08928

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 32 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS ECKHART	
3 NAME OF DECEASED (Type or print) MILDRED JULIA KIRBY		4 DATE OF DEATH Month JULY Day 9 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH DEC. 2, 1915
9 AGE (In years last birthday) yrs. 51		10 IF UNDER 1 Year Months 9 Days 9 Hours 24 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME CLARENCE BONE		14. MOTHER'S MAIDEN NAME ANNA MAY DAVIS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 217-10-5070		16 SOCIAL SECURITY NO. WM. R. KIRBY, ECKHART, MD.	
17. INFORMANT WM. R. KIRBY, ECKHART, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) chronic nephritis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepatic cirrhosis - diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 7, 1967 , to July 9, 1967 , that (I) (we) last saw the deceased alive on July 9, 1967 , and that death occurred at 11:30 P.M. from causes and on the date stated above			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED July 10, 1967	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JULY 12 '67	23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS CEMETERY	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24 FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE JUL 12 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE HEALTH DEPT.

08930

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08929

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. STREET ADDRESS 317 N. Centre Street	
3. NAME OF DECEASED (Type or print) First Regina Middle May Last Koegel		4. DATE OF DEATH Month July Day 12 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 7, 1900
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67 M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10b. KIND OF BUSINESS OR INDUSTRY Cumberland Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dawson Brant		14. MOTHER'S MAIDEN NAME Lucy Lattinger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO 214-05-9463	
17. INFORMANT Eugene Brant		Address 634 Shriver Ave Cumberland, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli DUE TO Conditions (only, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fracture of Left Hip DUE TO (c) 10 Days			INTERVAL BETWEEN ONSET AND DEATH 10 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fell at Home			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Fell at Home	
20c. TIME OF INJURY Month, Day, Year Hour 8:30 pm July 3 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Cumberland, Alleg. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED July 12, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county) Cumberland, Maryland		23. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/15/67	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Alleg Maryland	
24. FUNERAL DIRECTOR H. Lee Silcox		ADDRESS 404 Decatur Cumberland, Md	
25a. REC'D BY REGISTRAR JUL 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08931

CERTIFICATE OF DEATH

08931

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN IL 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		e. STREET ADDRESS 81 WASHINGTON ST.	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN WILLIAM KROLL		4. DATE OF DEATH Month Day Year JULY 15, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 1, 1880
9. AGE (in years last birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY COAL MINES	
11. BIRTHPLACE (County & State, or foreign country) FROSTBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERMAN KROLL		14. MOTHER'S MAIDEN NAME ANNA LAPP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 124-01-3749	
17. INFORMANT MR. HERMAN KROLL, 71 WASHINGTON ST.		18. FROSTBURG, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure DUE TO (b) Arteriosclerotic Cardiovascular DUE TO (c) Years		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nor While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 11, 1967 to July 15, 1967 , that (I) (we) last saw the deceased alive on July 15, 1967 , and that death occurred at 7:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE John B. Davis, M.D.		22b. DATE SIGNED 7/18/67	
22c. PHYSICIAN'S NAME (Type) JOHN B. DAVIS, M.D.		22d. ADDRESS 2 BROADWAY, FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK		23d. LOCATION (City or Town) (County) (State) FROSTBURG, MARYLAND	
24. FUNERAL DIRECTOR MARILOU M. SOWERS, HAFER-SOWERS FUNERAL		25a. REC'D BY REGISTRAR JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. HOME, 60W. MAIN, FROSTBURG	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
08932 CERTIFICATE OF DEATH 08931									
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland					c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital					d. STREET ADDRESS Dudley Street				
3. NAME OF DECEASED (Type or print) First JOHN Middle T. Last LEASE					4. DATE OF DEATH Month July Day 1st. Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 6th. 1902		9. AGE (In years last birthday) 64 IF UNDER 1 YEAR: Months 6 Days 4 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME *****					14. MOTHER'S MAIDEN NAME Margaret Lease				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Ethel Lease Lonaconing, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute respiratory insufficiency DUE TO Pulmonary emphysema and fibrosis ; Chronic (b) right ventricular failure DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 2hrs. 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.									
22a. SIGNATURE <i>Gina M. Glick M.D.</i>						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Gina M. Glick M.D.	
22d. ADDRESS Cumberland, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/3/1967		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town or county) (State) Moscow, Md.		
24. FUNERAL DIRECTOR George Eichhorn Lonaconing, Md.						25a. REC'D BY REGISTRAR JUL 3 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

CERTIFICATE OF DEATH

08932

28933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 131 ARCH STREET	
3 NAME OF DECEASED (Type or print) MAYNARD WILLIAM LEWIS		4 DATE OF DEATH Month JULY Day 22 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-1894
9. AGE (In years last birthday) 72 yrs.		10. FUND 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONDUCTOR		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA-Stephen City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CLARENCE LEWIS		14. MOTHER'S MAIDEN NAME NANNY CHAPMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Failure Art + dx / DUE TO (b) Leb. Cere Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumbr. Rd. Md.		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/19/67 , 19 to 7/22/67 , that (I) last saw the deceased alive on 7/21/67 , and that death occurred at 12:50 , from causes and on the date stated above.			
22a. SIGNATURE DR. R. J. WILLIAMS		22b. DATE SIGNED 7/24/67	
22c. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS		22d. ADDRESS 122 SO. CENTRE ST. CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 24, 1967	
23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Stephen City, Va.	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR JUL 26 1967	
		25b. REGISTRAR'S SIGNATURE James F. Scarpelli	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove upon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08934 CERTIFICATE OF DEATH 08934											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 46 DAYS		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL						d. STREET ADDRESS 314 FRANKLIN STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLOSSIE			First S. Middle S. Last LILLER			4. DATE OF DEATH Month JULY Day 3 Year 1967					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3'26'02		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) GORMANIA, WEST VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM SHIRCLIFF						14. MOTHER'S MAIDEN NAME PLEASANT (SMITHX)					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 220-16-5941-A		17. INFORMANT HOSPITAL RECORDS			Address SETON DRIVE CUMB., MD. 21502		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE										INTERVAL BETWEEN USUAL DEATH 10 YRS.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE										10 YRS.	
DUE TO (c) UREMIC POISONING										6 WKS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED OSTEOARTHRITIS AND ARTERIOSCLEROSIS											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) NONE							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MAY 18, 19 67 to JULY 3, 19 67 , that (I) (we) last saw the deceased alive on JULY 3, 19 67 , and that death occurred at 11:45 PM from the causes and on the date stated above.											
22a. SIGNATURE <i>James P. Hallinan M.D.</i>						ATTENDING # 74-67 M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-4-67			
22c. PHYSICIAN'S NAME (Type) DR. J. P. HALLINAN						22d. ADDRESS 140 BEDFORD ST., CUMB., MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 7, 1967		23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK				23d. LOCATION (City, town or county) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR BYRON KIGHT				ADDRESS CUMBERLAND, MD.		25a. REC'D BY REGISTRAR JUL 7 1967		25b. REGISTRAR'S SIGNATURE <i>James P. Hallinan</i>			

THE JOURNAL

OF THE

ROYAL SOCIETY

OF LONDON

Vol. 10, Pt. 1, 1911

— 1 —

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

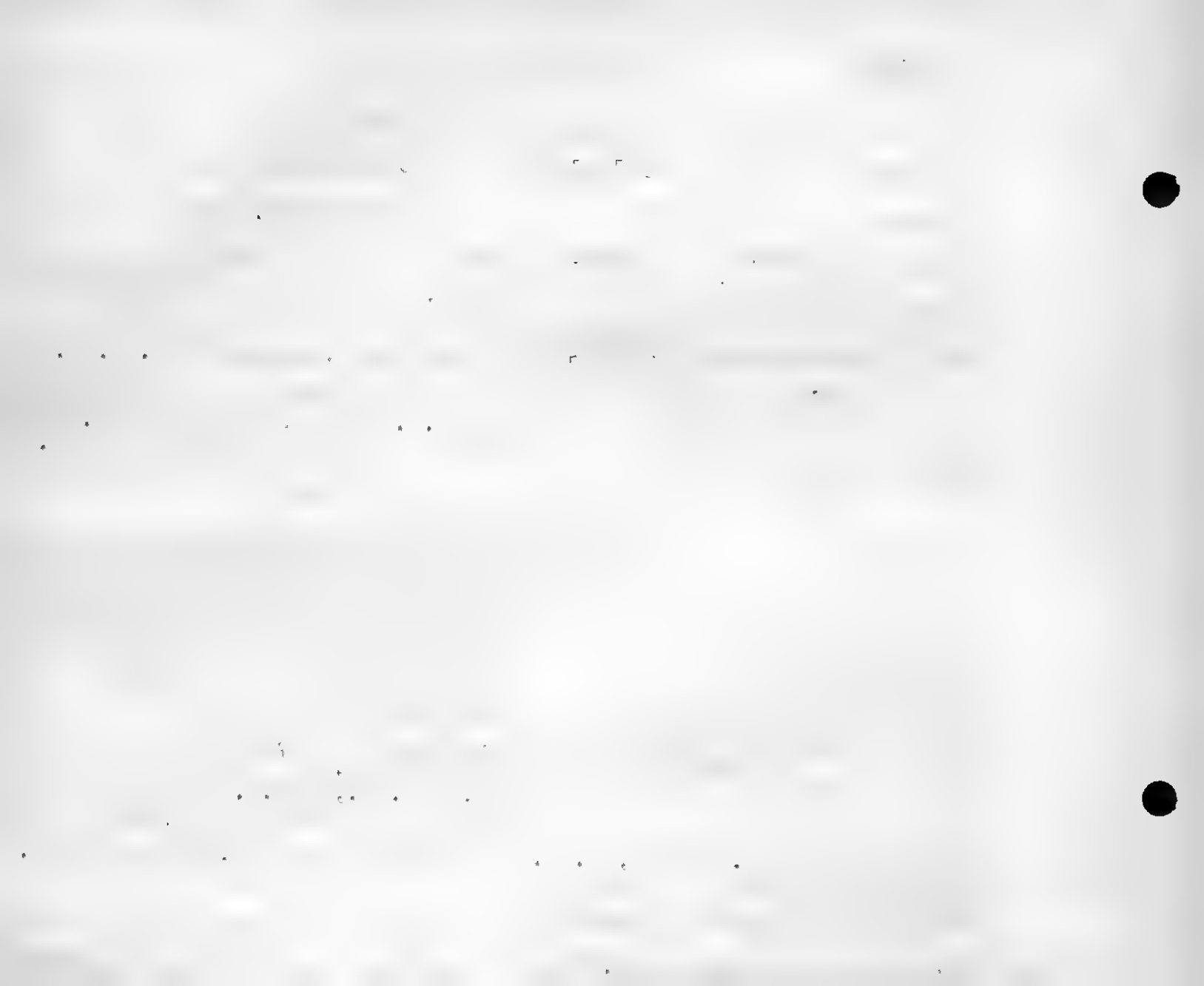
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08935

08934

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 3/15/1963	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 121 Bedford Street	
3 NAME OF DECEASED (Type or print) First Mary Middle Clara Last Lippold		4. DATE OF DEATH Month July Day 11 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/24/1882
9. AGE (In years last birthday) 85 yrs.		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Housekeeper for Hotel		11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland	
13. FATHER'S NAME Daniel Bradley		14. MOTHER'S MAIDEN NAME Ellen Joyce	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-05-8013	
17. INFORMANT P.O. Box 599, Cumberland, Md. 21502		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO (b) Generalized Arterio Sclerosis DUE TO (c) Chronic A.S.C.A.D. Interval between ONSET AND DEATH Four hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/15/1963 , 19____, to 7/11/67 , 19____, that (I) (we) last saw the deceased alive on 7/10/67 , 19____, and that death occurred at P. M., from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED 7/11/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-13-67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany MD.
24 FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR JUL 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 404 Decatur St. Cumb. Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08936

08935

FOR STATE HEALTH DIVISION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY **Allegany** MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Cumberland** c. LENGTH OF STAY IN 1b **50 years**

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) **315 Pennsylvania Avenue**

2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission)
e. STATE **Maryland** b. COUNTY **Allegany**

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) **Cumberland** d. STREET ADDRESS **315 Pennsylvania Avenue**

3. NAME OF DECEASED (Type or print) First Middle Last **Walter W. Logue**

4. DATE OF DEATH Month Day Year **July 14 1967**

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **Dec. 22, 1915** 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) **51** yrs Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Baker** 10b. KIND OF BUSINESS OR INDUSTRY **Self Employed** 11. BIRTHPLACE (State or foreign country) **Cumberland, Md.** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **William Theodore Logue** 14. MOTHER'S MAIDEN NAME **Myrtle Miller**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **yes** 16. SOCIAL SECURITY NO. **War II** 17. INFORMANT Address **Mrs. Marie Logue, Cumberland, Md.-Wife**

18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **4201** DUE TO **CORONARY OCCLUSION**
Conditions, if any, which gave rise to immediate cause (b) **CORONARY SCLEROSIS**
(c), stating the underlying cause last. DUE TO (c) **---**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

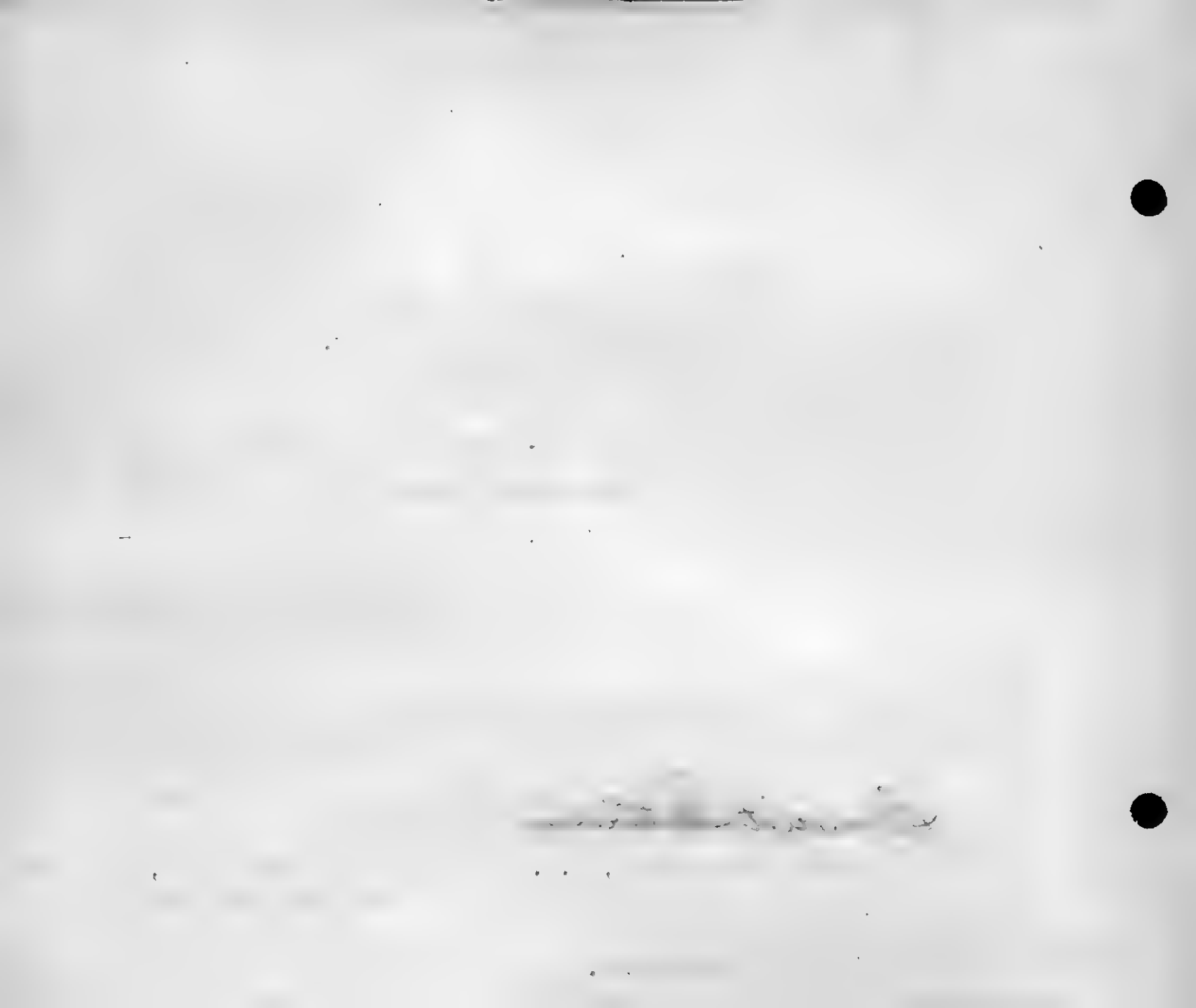
ACTUAL **Benedict Skitarelic** CHIEF MEDICAL EXAMINER ☐ July 14, 1967
ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) **BENEDICT SKITARELIC, M.D.** Address (Street, city, town, or county) **CUMBERLAND, MARYLAND**

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **July 14, 1967** 22c. NAME OF CEMETERY OR CREMATORY **Mt. Hermon Cemetery** 22d. LOCATION (City, town, or country) (State) **Cumberland, Md. Allegany**

23. FUNERAL DIRECTOR **James F. Scarpelli, Cumberland, Md.** ADDRESS

24a. REC'D BY REGISTRAR **JUL 18 1967** 24b. REGISTRAR'S SIGNATURE **Charles Judge**



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

98937

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03030

1 PLACE OF DEATH a. COUNTY ALLEGANY		2 USUAL RESIDENCE (Where deceased lived, if first tution Residence before admission) a STATE MARYLAND		b COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE		c LENGTH OF STAY IN 1b LIFE		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE (SLABTOWN)	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) PAUL W. MARTIN		4 DATE OF DEATH Month JULY , Day 2 , Year 1967			
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MARCH 8, 1903	9 AGE (In years last birthday) 64	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PLASTERER		10b KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED		11 BIRTHPLACE (State or foreign country) MARYLAND	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME ARMOND MARTIN		14 MOTHER'S MAIDEN NAME NORA DAVIDSON	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO 216-03-8942		17 INFORMANT Address MRS. MARTHA TRULY, MT. SAVAGE, MD.	
18a CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot of head</u> DUE TO (b) <u>(Self inflicted)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____			
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f (City or town) _____ (County) _____ (State) _____					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
22. DATE SIGNED July 2, 1967		23. SIGNATURE OF REGISTRAR Charles J. Jager			
24. BUREAU OF HEALTH REMOVAL (Specify) BURIAL		25. DATE THEREOF JULY 5, 1967		26. NAME OF CEMETERY OR CREMATORY METHODIST CEMETERY	
27. LOCATION (City or Town) _____ (County) _____ (State) _____		28. NAME OF CEMETERY OR CREMATORY MT. SAVAGE, MD.			
29. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		30. ADDRESS MT. SAVAGE, MD.			

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

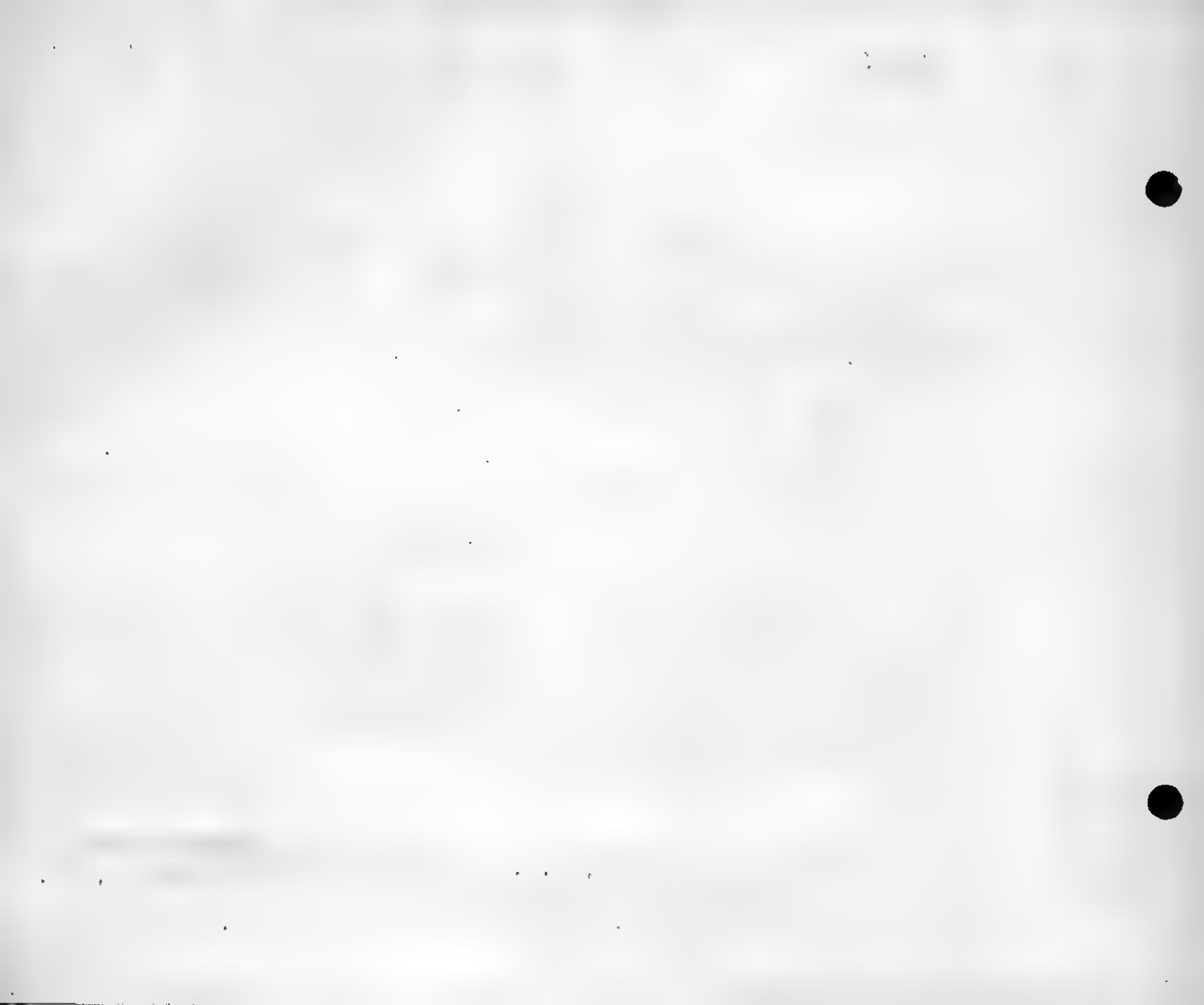
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08938

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08937

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY (In days) 4½ years	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 24 Browning Street		d. STREET ADDRESS 24 Browning Street	
3. NAME OF DECEASED (Type or print) First Jesse Middle Alvin Last McCain		4. DATE OF DEATH Month July Day 9 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 19, 1894
9 AGE (in years last birthday) 72 yrs		10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lt. Guard		10b. KIND OF BUSINESS OR INDUSTRY U. S. Printing Office-Lafayette, Ala.	
11. BIRTHPLACE (State or foreign country) USA		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Jackson McCain		14. MOTHER'S MAIDEN NAME Ada Elizabeth Reed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes War I		16. SOCIAL SECURITY NO	
17 INFORMANT Mrs. Grace Fleming, Cumberland, Md.		Address	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Sclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of form 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 12, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland Md. Allegany
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR JUL 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate must be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR AISME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 08939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08939

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Westernport c. LENGTH OF STAY IN 1b 14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Moscow Mills d. STREET ADDRESS a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Everett Wilson McCarty				4. DATE OF DEATH Month July Day 28 Year 1967									
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1877		9. AGE (In years last birthday) 90 IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY self employment		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry McCarty				14. MOTHER'S MAIDEN NAME Not Known									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 00		17. INFORMANT Address Charles McCarty-Westernport, Md.									
MEDICAL CERTIFICATION						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary sclerosis DUE TO (c) Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Minutes Years					
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
						20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) Benedict Skitarelic 22. DATE SIGNED 7/28/67 Address (Street, city, town, or county) Cumberland, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7/31/67		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town or county) (State) Westernport, Md.							
24. FUNERAL DIRECTOR C. L. Beal ADDRESS Westernport, Md.				25a. REC'D BY REGISTRAR OATE AUG 2 1967				25b. REGISTRAR'S SIGNATURE Charles Judge					

CERTIFICATE OF DEATH

38940

08933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 14 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL-CUMB., MD.		d. STREET ADDRESS 405 MD. AVE.,	
3. NAME OF DECEASED (Type or print) BEULAH First A. Middle MC CLOSKEY Last		4 DATE OF DEATH Month JULY Day 20 Year 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-27-07
9 AGE (In years last birthday) yrs 60		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) ALLEGANY, MARYLAND	
13. FATHER'S NAME WILLIAM E. REID		12 CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME ANNA (CADWALLADER)		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) X NO	
16. SOCIAL SECURITY NO 214-05-5133		17 INFORMANT PT'S. HOSPITAL RECORD-SACRED HEART HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral anoxia 4500 DUE TO Postoperative thromboembolism Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last left common carotid artery due to arteriosclerosis DUE TO arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7-6-67 19 to 7-20-67 , that (I) (we) last saw the deceased alive on 7-20-1967 , and that death occurred 7:15 P M, from causes and on the date stated above.			
22a. SIGNATURE Earl R. Paul		22b. DATE SIGNED 7/25/67	
22c. PHYSICIAN'S NAME (Type) EARL R. PAUL, M.D.		22d. ADDRESS 36 GREENE STREET CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 24, 1967	
23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK		23d. LOCATION (City or Town) (County) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR BYRON KIGHT		25a. REC'D BY REGISTRAR JUL 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Jones	

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 9/24/1959	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		d. STREET ADDRESS 130 Polk Street	
3. NAME OF DECEASED (Type or print) Margaret		4. DATE OF DEATH Month July Day 10 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/7/1872
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Moscow, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David Tennant		14. MOTHER'S MAIDEN NAME Agnes McArthur	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT P.O.Box 599, Cumberland, Md. 21502		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Senile Cachexia DUE TO (b) Chc. A.S.H.D. with Arterio Sclerosis + Mitral Insufficiency DUE TO (c) Senile Arterio Sclerosis INTERVAL BETWEEN ONSET AND DEATH approx. 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cataracts, Bilateral. Fracture, lt. hip - old - unhealed.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept. 24, 19 59 to July 10, 19 67 that (I) (we) last saw the deceased alive on July 8, 1967 , and that death occurred at A. M. from causes and on the date stated above.			
22a. SIGNATURE John A. Topper		22b. DATE SIGNED July 10, 1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 7/12/67	
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR H. Wayne George		25a. REC'D BY REGISTRAR DATE JUL 13 1967	
25b. REGISTRAR'S SIGNATURE Charles J. [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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08941

08942

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm'ssion) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB 5/16/1966	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage,		d. STREET ADDRESS New Row,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Elizabeth Last Mollotti		4. DATE OF DEATH Month July Day 4, Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/1883
9. AGE (In years last b rthday) 84 yrs		10. IF UNDER 1 YEAR Months 4, Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Rowan		14. MOTHER'S MAIDEN NAME Mary Powers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO	
17. INFORMANT P.O. Box 599, Cumberland, Md. 21502		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Approx. 2 years Anterior-Septic - Skin - Several years Colo. A.S.C.V. - 2-3 years	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/16/1966 to 7/4/1967 , that (I) (we) lost saw the deceased alive on 7/3/1967 , and that death occurred at P. M. from causes on and on the date stated above at 10:45 P.M., D.S.T.			
22a. SIGNATURE John A. Topper, M. D.		22b. DATE SIGNED 7/5/1967	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 7, 1967	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Lonaconing, Md. Allegany	
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUL 10 1967	
25b. REGISTRAR'S SIGNATURE James F. Scarpelli			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08943

03942

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 20 MINS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 122 POLK ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle M. Last MEYERS				4. DATE OF DEATH Month JULY Day 26 Year 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-08	9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS GRADY				14. MOTHER'S MAIDEN NAME LAURA THOMAS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO (b) CHRONIC MYOCARDITIS DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						INTERVAL BETWEEN ONSET AND DEATH 2 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from JAN 18 1967 to JULY 18 1967 , that (I) (we) last saw the deceased alive on JULY 26 1967 , and that death occurred at 10:20 A.M. , from causes and on the date stated above							
22a. SIGNATURE G.O. HIMMELWRIGHT, M.D.				22b. DATE SIGNED JULY 28, 1967		22c. PHYSICIAN'S NAME (Type) XXXXXXXXXXXXXXS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 28, 1967	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland, Md. Allegany		
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE JUL 31 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J. [Signature]</i>	

CERTIFICATE OF DEATH

08943

08944

1 PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b 6 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg d. STREET ADDRESS 20 Beall Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Joseph M. Miller		4 DATE OF DEATH Month July Day 2 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1882
9. AGE (In years last birthday) 85 yrs		10. IF UNDER 1 YEAR Months 3 Days 16	11. IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) City Employee		10b. KIND OF BUSINESS OR INDUSTRY City of Frostburg Allegany Maryland	
11 BIRTHPLACE (County & State, or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrance Miller		14. MOTHER'S MAIDEN NAME Mary Martin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 220-07-6941	
17. INFORMANT Mrs. Viola Miller		Address 20 Beall St.	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Brain Syndrome DUE TO (b) due to circulatory disturbance DUE TO (c) Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 6/26 , 19 67 , to 7/2 , 19 67 , that (I) (we) last saw the deceased alive on 7/2 , 19 67 , and that death occurred at 5:45 PM , from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED 7/3/67	
22c. PHYSICIAN'S NAME (Type) A. Paige Strong		22d. ADDRESS 167 East Main St. Frostburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 5, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Michaels	23d. LOCATION (City or Town) (County) (State) Frostburg Allegany Md.
24. FUNERAL DIRECTOR Marilou M. Sowers		25a. REC'D BY REGISTRAR Jul 6 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jager		25c. ADDRESS 60 W. Main, Frostburg	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 38945									
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>50 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>813 Lafayette Avenue</u>					d. STREET ADDRESS <u>813 Lafayette Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Providence</u> Middle <u>Miller</u> Last <u>Miller</u>			4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1967</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>March 23, 1891</u>		9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR (If UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Gilpin Town, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elisha H. Furlow</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Pennell</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Miss Sarah E. Bucy, Cumberland, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>321V</u> DUE TO <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 yrs</u> <u>? yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1966, to <u>July 11</u> , 1967, that (I) (we) last saw the deceased alive on <u>July 13</u> , 1967, and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>A. J. Mirkin</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>July 12, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. A. J. Mirkin, M.D.</u>					22d. ADDRESS <u>115 S. Centre St. Cumberland, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Md. Allegany</u>			
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JUL 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

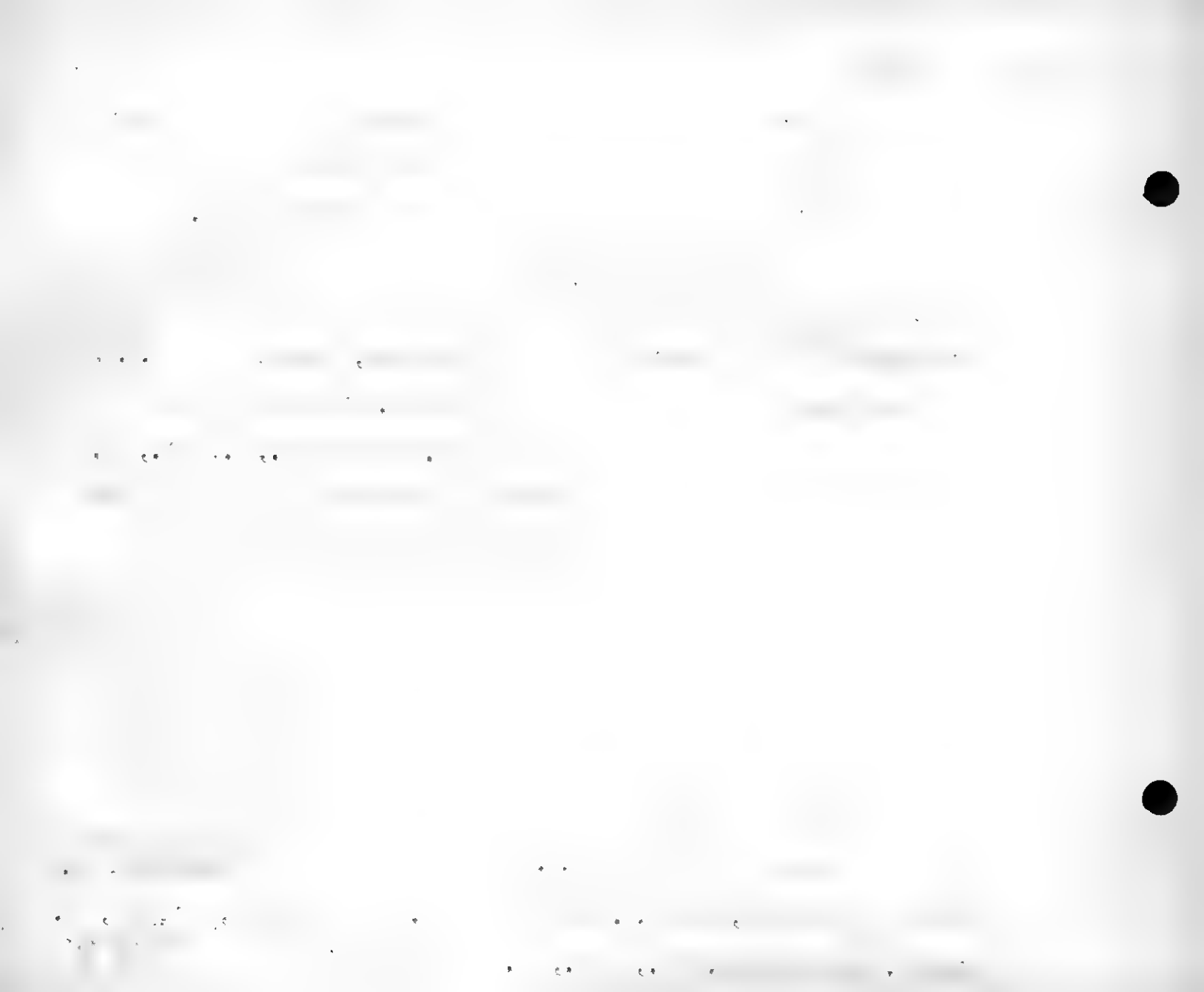
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08946

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08945

1. PLACE OF DEATH a. COUNTY Allegheny MARYLAND		2. USUAL RESIDENCE (Where deceased lived, institution Residence before admission) a. STATE Maryland b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 Day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		d. STREET ADDRESS 36 Pennsylvania Ave.	
3. NAME OF DECEASED (Type or print) JOHN FRANCIS MINKE		4. DATE OF DEATH Month July Day 17 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1898
9. AGE (In years last birthday) 69 yrs		10. F UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright		10b. KIND OF BUSINESS OR INDUSTRY Textile	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Minke		14. MOTHER'S MAIDEN NAME Mary C. Hipshman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Lottie H. Minke 36 Pa. Ave., Cumb., Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Hypertensive Cardiovascular disease --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED July 17, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR Philip B. Wendt 121 Mem. Ave., Cumb., Md.		25a. REC'D BY REGISTRAR JUL 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

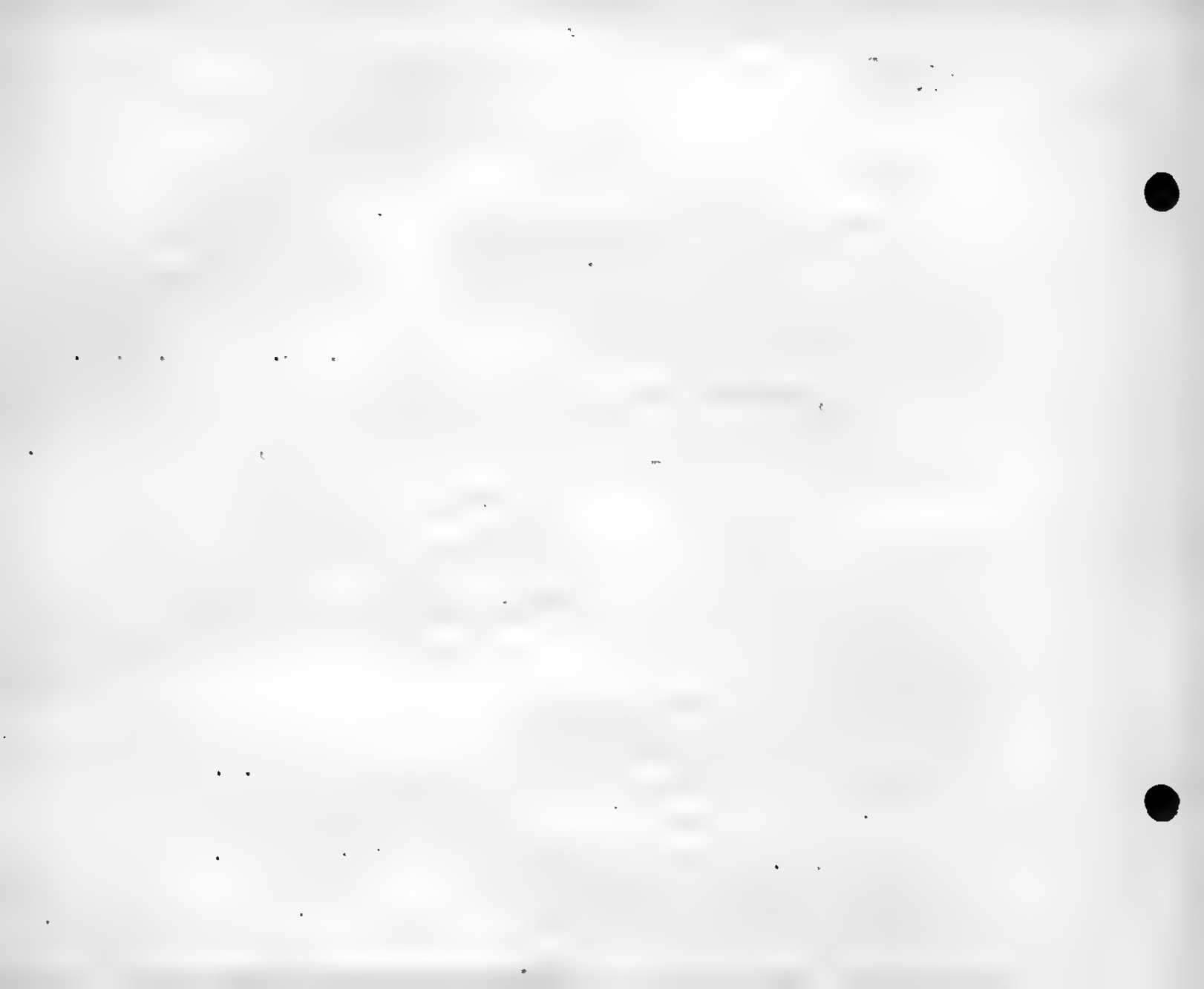
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08947

CERTIFICATE OF DEATH

08946

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on; Residence before adm ssion) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 17 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RT 2 BOX 179	
3. NAME OF DECEASED (Type or print) First PEARL Middle I. Last MORGAN		4. DATE OF DEATH Month JULY Day 8 Year 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-1920
9. AGE (In years lost birthday) yrs 47		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	
11. BIRTHPLACE (County & State, or foreign country) SOMERSET CO. PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FRIEDLINE, SHANNEX Chancey		14. MOTHER'S MAIDEN NAME LAURA GROSS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 170-18-0215	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Pulmonary Embolus DUE TO (b) Phlebotrombosis DUE TO (c) Varicose Veins		INTERVAL BETWEEN ONSET AND DEATH Seconds	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Phlegmonous Erysipelas			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1954 , 19 9:40 P.M. , 19 67 , that (I) (we) last saw the deceased alive on July 8 , 19 67 , and that death occurred at 9:40 P.M. , from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 7/11/67	
22c. PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7-11-67	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.	
24. FUNERAL DIRECTOR H. Lee Silcox		25a. REC'D BY REGISTRAR JUL 12 1967	
ADDRESS 404 Decatur St. Cumb. Md.		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

08948

CERTIFICATE OF DEATH

08947

1 PLACE OF DEATH a COUNTY <u>Allegany</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Res. dence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c LENGTH OF STAY IN 1b <u>3 months</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sylvan Retreat</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Josephine</u> Last <u>Mullan</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 16, 1887</u>
9 AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Allegany Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Enoch McKenzie</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Rohman</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>NONE</u>	
17 INFORMANT <u>PAUL MULLAN</u>		Address <u>CUMBERLAND, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 12, 1967</u> , to <u>July 1, 1967</u> , that (I) (we) lost saw the deceased alive on <u>July 1, 1967</u> , and that death occurred at <u>7 P.M.</u> from causes and on the date stated above.			
22a SIGNATURE <u>George M. Simons</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <u>7/1/67</u>
22c. PHYSICIAN'S NAME (Type) <u>GEORGE M. SIMONS</u>		22d ADDRESS <u>Memorial Hospital</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b DATE THEREOF <u>JULY 5, 1967</u>	23c NAME OF CEMETERY OR CREMATORY <u>ST. PETER & PAUL CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>CUMBERLAND, MD.</u>
24. FUNERAL DIRECTOR <u>BYRON KIGHT</u>		ADDRESS <u>CUMBERLAND, MD.</u>	25a REC'D BY REGISTRAR DATE <u>JUL 6 1967</u>
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

CERTIFICATE OF DEATH

08943

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN tb 40 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 45 S. WATER STREET	
3. NAME OF DECEASED (Type or print) ANNA K. MYERS		4. DATE OF DEATH JULY 11, 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 21, 1863
9. AGE (In years last birthday) 103 yrs		10. IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME WILLIAM THOMAS		14. MOTHER'S MAIDEN NAME NANCY BOWLIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 220-52-9657-1	
17. INFORMANT MABEL MYERS, FROSTBURG, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC BRAIN SYNDROME DUE TO (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) 17 YEAR			INTERVAL BETWEEN ONSET AND DEATH 17 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 3, 1967 , to July 11, 1967 , that (I) (we) last saw the deceased alive on July 10, 1967 , and that death occurred at 9:25 AM , from causes and on the date stated above.			
22a. SIGNATURE G. Paige Strong		22b. DATE SIGNED July 11, 1967	
22c. PHYSICIAN'S NAME (Type) A. PAIGE STRONG, M. D.		22d. ADDRESS E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JULY 13, 1967	23c. NAME OF CEMETERY OR CREMATORY FB'G. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24. FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a. REC'D BY REGISTRAR JUL 12 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>38950</p> <p>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</p> </div> <div> <p>08549</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN 1b 10 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kolbergs Hill					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport d. STREET ADDRESS Kolbergs Hill e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Ethel Mae Myers First Middle Last 4. DATE OF DEATH July 2 1967 Month Day Year					5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 29, 1897 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME William Emerson 14. MOTHER'S MAIDEN NAME Elizabeth Whiteman						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)					16. SOCIAL SECURITY NO. 17. INFORMANT Leonard H. Myers-Westernport, Md. Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Coronary sclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. EXAMINER'S NAME (Type) Benedict Skitarelic CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										22. DATE SIGNED 7-2-67 Address (Street, city, town, or county) Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 7/5/67 23c. NAME OF CEMETERY OR CREMATORY Philos 23d. LOCATION (City, town or county) (State) Westernport, Md.					24. FUNERAL DIRECTOR <i>E. J. Boal</i> Westernport, Md. ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JUL 10 1967 <i>Charles J. Jones</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08951

CERTIFICATE OF DEATH

08950

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.		c. LENGTH OF STAY IN 1b 88 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. STREET ADDRESS 225 FREDRICK ST.	
3. NAME OF DECEASED (Type or print) First VIRGIE Middle B. Last NAUGHTON		4. DATE OF DEATH Month JULY Day 18 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-87
9. AGE (In years last birthday) yrs 79		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, ALLEGANY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME IRA MOXLEY		14. MOTHER'S MAIDEN NAME LOUISE SPRINKLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-07-4920	
17. INFORMANT HOSPITAL RECORD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT DUE TO Long-stand cardiac vascular disease DUE TO + diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture neck left femur		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell out of bed in hospital	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 4:24 19 67 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Cumberland, Alleg. Md.	
21. I certify that (I) (this hospital) attended the deceased from 5-24-67 to 7-18-67 , that (I) (we) lost saw the deceased alive on 7-12-67 , and that death occurred at 12 A -M, from causes and on the date stated above.			
22a. SIGNATURE Robert F. Feddis		22b. DATE SIGNED 7-19-67	
22c. PHYSICIAN'S NAME (Type) ROBERT FEDDIS		22d. ADDRESS 500 Greene St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 21, 1967	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR KIGHT FUNERAL HOME-309 DECATUR-CUMBERLAND, MD.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 24 1967	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08952

CERTIFICATE OF DEATH

08951

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSPITAL		d. STREET ADDRESS 164 BOWERY STREET	
3 NAME OF DECEASED (Type or print) VELMA ELIZABETH NEAL		4 DATE OF DEATH JULY 12, 1967	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MARCH 14, 1893
9 AGE (In years last birthday) 74		10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE MANAGER	
11 BIRTHPLACE (County & State, or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALEXANDER C. NEAL		14 MOTHER'S MAIDEN NAME MARY ANN JACOBS	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO. 217-14-4917	
17 INFORMANT MISS NEDA K. NEAL, FROSTBURG, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 443x IMMEDIATE CAUSE (a) Cerebral Hemorrhage - rt. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension - Arteriosclerotic CVD - 10 yrs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/9 , 1967, to 7/12 , 1967, that (I) (we) lost saw the deceased alive on 7/12 1967, and that death occurred at 1:50 PM , from causes and on the date stated above			
22a SIGNATURE Martin M. Rothstein		22b DATE SIGNED 7/14/67	
22c PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN,		22d ADDRESS 48 BROADWAY, FROSTBURG, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF JULY 15 '67	
23c NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK		23d LOCATION (City or Town) (County) (State) FROSTBURG, MD.	
24 FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a RECD BY REGISTRAR JUL 17 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item # 8 Film # G391 1/27 37 ph									
08953 CERTIFICATE OF DEATH 08952									
1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 1WK 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS RT. #5,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) LESTER B. PATTERSON					4. DATE OF DEATH Month JULY Day 28 Year 1967				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1909 2-22-1909		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CELANESE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) KEYSER, W. VA.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL PATTERSON					14. MOTHER'S MAIDEN NAME MARY ARMENTROUT				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 214-07-3359		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus, bilateral, massive DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial infarction, recent, posterior									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-21-1967 to 7-28-1967 that (I) (we) last saw the deceased alive on 7-27-1967 , and that death occurred at 6:30AM from causes and on the date stated above.									
22a. SIGNATURE Dr. R. Schindler					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-7-67		
22c. PHYSICIAN'S NAME (Type) DR. R. SCHINDLER					22d. ADDRESS CUMBERLAND, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 31, 1967		23c. NAME OF CEMETERY OR CREMATORY Queens Point Cem.			23d. LOCATION (City or Town) (County) (State) Keyser, W. Va.		
24. FUNERAL DIRECTOR Geo. K. Chambers					ADDRESS Keyser, W. Va.		25a. REC'D BY REGISTRAR DATE AUG 4 1967		25b. REGISTRAR'S SIGNATURE Charles Judge



38954

CERTIFICATE OF DEATH

38953

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE PENNSYLVANIA b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 10HRS. 45MIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. STREET ADDRESS WELLERSBURG	
3. NAME OF DECEASED (Type or print) HARVEY First Middle Last E. POORBAUGH		4. DATE OF DEATH Month JULY Day 16 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-24-1875 9. AGE (In years last birthday) 91 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Schellsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM H. POORBAUGH		14. MOTHER'S MAIDEN NAME SARAH BLUBAUGH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-03--0859	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: 500X IMMEDIATE CAUSE (a) <u>Pneumonia (RLL)</u> DUE TO (b) <u>Pleural effusion - Rt</u> DUE TO (c) <u>Acute tracheo-bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH Few days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gent atherosclerosis & senility		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour, a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 16, 1967 , to same day , that (I) (we) lost saw the deceased alive on July 16, 1967 , and that death occurred at 11:45 PM on the date stated above.			
22a. SIGNATURE Dr. Mirkin MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. MIRKIN		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 20, 1967	
23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION (City or Town) (County) (State) Berlin, RD#1, Somerset Co., Pa	
24. FUNERAL DIRECTOR Harvey H. Zeigler		25a. REC'D BY REGISTRAR Hyndman, Pa.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE JUL 21 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08955

08954

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 77 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 525 FORT AVENUE			
3. NAME OF DECEASED (Type or print) ALSTON M.				4. DATE OF DEATH Month 7 Day 11 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-04	
9. AGE (In years last birthday) 63 yrs.				10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7 Days 11 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER				10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (County & State, or foreign country) BERKLEY SPRINGS, W. VA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM				14. MOTHER'S MAIDEN NAME JOSEPHINE (GIBBS)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 294-09-2642		17. INFORMANT HOSPITAL RECORD	
				Address SETON DRIVE CUMBERLAND, MD. 21502			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Influenza Chronic Bronchitis (b) Chronic Pneumonia DUE TO Chronic Pneumonia (c) Chronic Pneumonia							INTERVAL BETWEEN ONSET AND DEATH 14 days 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 11, 1967 , to July 11, 1967 , that (I) (we) last saw the deceased alive on July 11, 1967 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE D. B. Schindler				22b. DATE SIGNED July 14/67			
22c. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER, MD.				22d. ADDRESS 43 GREENE STREET, CUMB., MD. 21502			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/67		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		23d. LOCATION (City, town or county) (State) Cumberland Allegany Md.	
24. FUNERAL DIRECTOR KIGHT FUNERAL HOME, 309 DECATUR ST., CUMB., MD.				25a. REC'D BY REGISTRAR JUL 17 1967 25b. REGISTRAR'S SIGNATURE [Signature]			

2015

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2015

(2)

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08956

CERTIFICATE OF DEATH

08955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EVERETT - RURAL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS RT. #3	
3 NAME OF DECEASED (Type or print) First GRACE Middle ANNA Last PRICE		4 DATE OF DEATH Month JULY Day 16 Year 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-13-1914
9 AGE (In years last birthday) 53 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) EVERETT, PA.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME JOHN H. CALHOUN		14. MOTHER'S MAIDEN NAME ANNA GRIMES	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 177-24-8859	
17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma, sigmoid with general metastasis DUE TO (b) Has colostomy and perineal fistula DUE TO (c) Has colostomy and perineal fistula Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patient has been under care Dr. Thomas Lewis who is now on vacation			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 7 , 19 67 to July 18 , 19 67 , that (I) (we) last saw the deceased alive on 7-14 , 19 67 , and that death occurred at 4:20 A.M. from causes and on the date stated above			
22a. SIGNATURE Carlton Brinsfield		22b. DATE SIGNED 7/16/67	
22c. PHYSICIAN'S NAME (Type) DR. XXXXX CARLTON BRINSFIELD		22d. ADDRESS CUMBERLAND, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/18/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Union Cemetery	23d. LOCATION (City or Town) (County) (State) W. Prov. Twp., Bed. Co., Pa.
24 FUNERAL DIRECTOR Lyford V. Conner		25a. REC'D BY REGISTRAR JUL 21 1967	
ADDRESS Everett, Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	

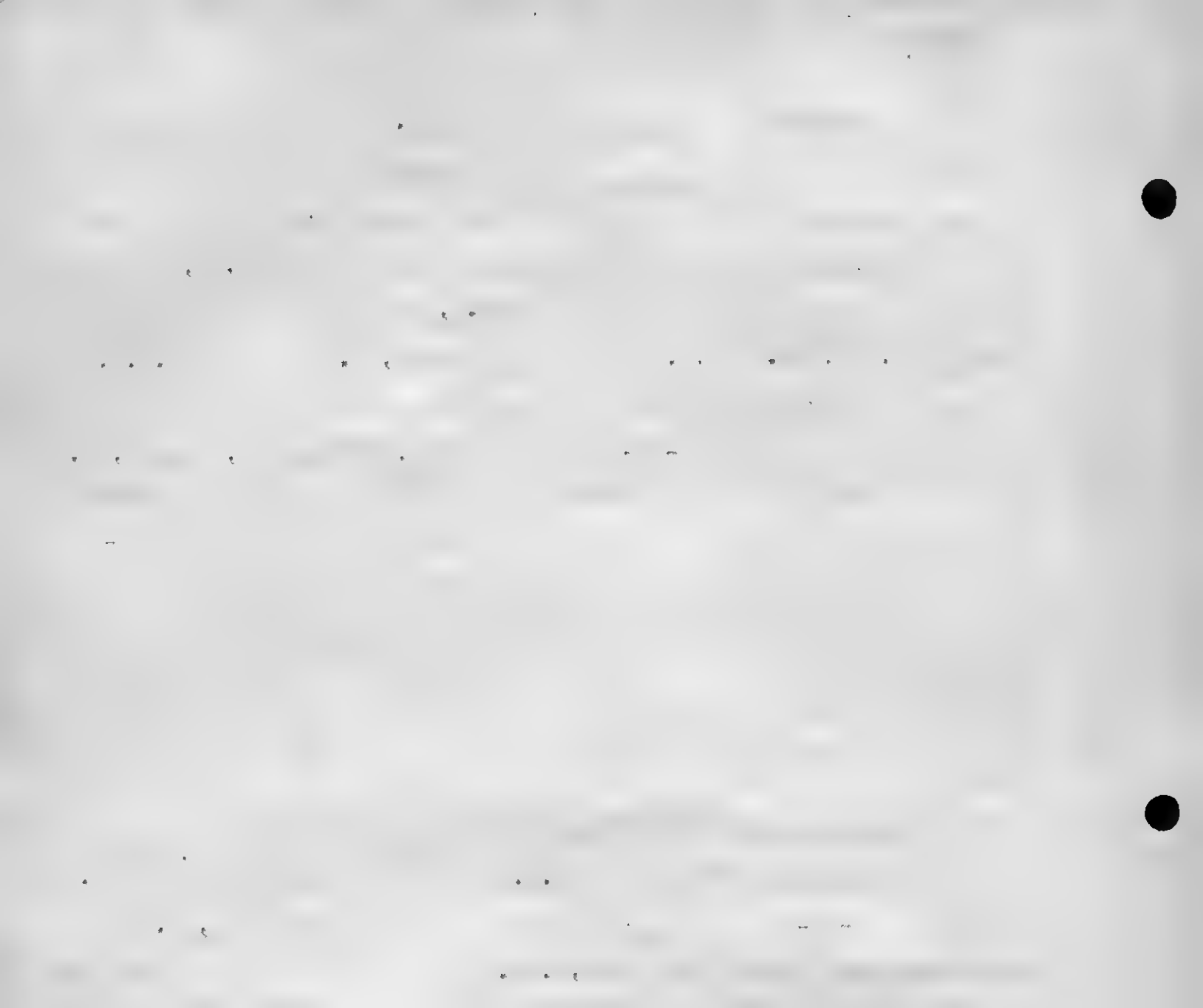


12
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
08955 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08955

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>McCoole</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Home 46 Howard Street</u>				d. STREET ADDRESS <u>46 Howard Street</u>			
3. NAME OF DECEASED (Type or print) <u>Howard Percy Ravenscroft</u>				4. DATE OF DEATH <u>July 25, 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1, 1898</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR <u>0</u> Months <u>24</u> Days		IF UNDER 24 HRS. <u>0</u> Hours <u>24</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired B. & O. Eng.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>			
11. BIRTHPLACE (State or foreign country) <u>McCoole, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Walter Edgar Ravenscroft</u>				14. MOTHER'S MAIDEN NAME <u>Ida Belle Clark</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-09-7275</u>			
17. INFORMANT <u>Donald H. Ravenscroft, McCoole, Md.</u>				Address <u>(Son)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 4201 Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (a), stating the underlying cause last. (c) <u>SUDDEN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>7-28-67</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Westernport, Md.</u>			
23. FUNERAL DIRECTOR <u>Shannon Smith Jr.</u>				24a. REC'D BY REGISTRAR <u>Keyser, W. Va.</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08958

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08957

1. PLACE OF DEATH
a. COUNTY Allegheny MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN b. 80 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kinch Nursing Home-606 Maryland Ave.
e. STREET ADDRESS 609 Maryland Avenue
f. RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Allegheny
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. DATE OF DEATH July 28 19 67
e. AGE (In years last birthday) 89 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS

3. NAME OF DECEASED (Type or print) Elizabeth Catherine Robinette
4. SEX Female 5. COLOR OR RACE White 6. MARRIED ☐ NEVER MARRIED ☐ 7. DATE OF BIRTH March 27, 1878
8. WIDOWED ☒ 9. DIVORCED ☐ 10. AGE (In years last birthday) 89 IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Fort Ashby, W. Va. 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry J. Willison 14. MOTHER'S MAIDEN NAME Rebecca Douthitt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) ☐ 16. SOCIAL SECURITY NO. 16 17. INFORMANT Mrs. Betty Dean, Cumberland, Md. Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion
4201 DUE TO Coronary Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ---
(c) ---
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While ☐ at work Not While ☐ at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. IC ty or town (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarolic CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) BENEDICT SKITAROLIC, M.D. ASSISTANT MEDICAL EXAMINER [] DATE SIGNED July 27, 1967
DEPUTY MEDICAL EXAMINER ☒ Cumberland, Maryland
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 30, 1967 22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery 22d. LOCATION (City, town, or country) (State) Fort Ashby, W. Va. Mineral C.

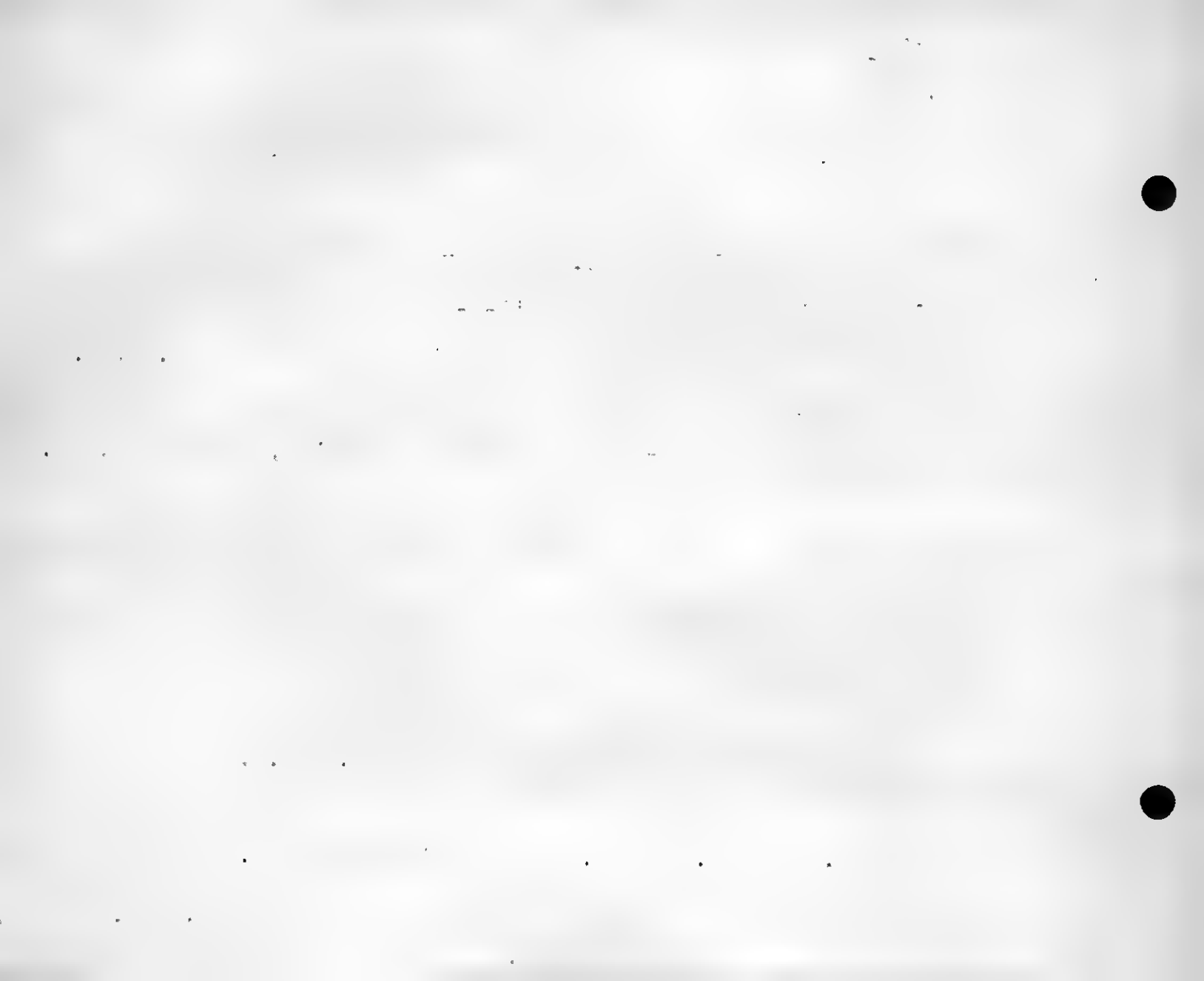
23. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md. ADDRESS
24a. REC'D BY REGISTRAR AUG 1 1967 24b. REGISTRAR'S SIGNATURE Charles J. J...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible handwriting]

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 08958										
CERTIFICATE OF DEATH					08958					
1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 50 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOUNT SAVAGE					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS RT 1			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First MARGARET Middle E. Last ROBY					4. DATE OF DEATH Month JULY Day 3 Year 19 67					
5. SEX FEMALE		6 COLOR OR RACE WHITE		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-16		9. AGE (In years last birthday) 50 yrs.		
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PENNA		12 CITIZEN OF WHAT COUNTRY? U. S. A.		
13 FATHER'S NAME SAMUEL GRAY					14. MOTHER'S MAIDEN NAME ANNA STEVANAS					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16 SOCIAL SECURITY NO 172-18-1788		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) SARCOMA, UTERUS WITH. DUE TO (b) BILATERAL PULMONARY METASTASIS DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 2 + years 8 months		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from Nov. 1966 , 19:47 P.M. July 3, 1967 , that (I) (we) last saw the deceased alive on July 3 1967 , and that death occurred at 7 M, from causes and on the date stated above.										
22a. SIGNATURE Wylie M Faw Jr.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 4, 1967			
22c. PHYSICIAN'S NAME (Type) DR. WYLIE M. FAW JR.					22d. ADDRESS CUMBERLAND, MD.					
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jul 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery			23d. LOCATION (City or Town) (County) (State) Meyersdale, Som. Co., Pa			
24 FUNERAL DIRECTOR William Brown Price					ADDRESS 325 Main St. Meyersdale, Pa.		25a. REC'D BY REGISTRAR JUL 10 1967		25b REGISTRAR'S SIGNATURE Charles J. J...	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08950

38960

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove collar papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 39 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL-CUMB., MD.		e. STREET ADDRESS 322 CUMBERLAND ST., CUMB., MD.	
3. NAME OF DECEASED (Type or print) First MARY Middle H. Last ROHMAN		4. DATE OF DEATH Month JULY Day 24 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1903 AUG., 8, 1903
9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CATERER		10b. KIND OF BUSINESS OR INDUSTRY CATERING	11. BIRTHPLACE (County, State, or foreign country) CUMBERLAND ALLEGANY, MD.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE HARTMAN	
14. MOTHER'S MAIDEN NAME ANN ELIZABETH BENDER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 219-03-8947		17. INFORMANT PT'S HOSPITAL CHART-SACRED HEART HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum with metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 9 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from October , 19 66 , to 24 July , 19 67 , that (I) (we) last saw the deceased alive on 7-24 19 67 , and that death occurred at 11:00 AM, from causes and on the date stated above.			
22a. SIGNATURE Andrew Stasko		22b. DATE SIGNED 7-25-67	
22c. PHYSICIAN'S NAME (Type) ANDREW STASKO, M.D.		22d. ADDRESS 401 DECATUR ST., CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 27, 1967	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery Cumberland, Md. Allegany	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR JUL 31 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. Inge	

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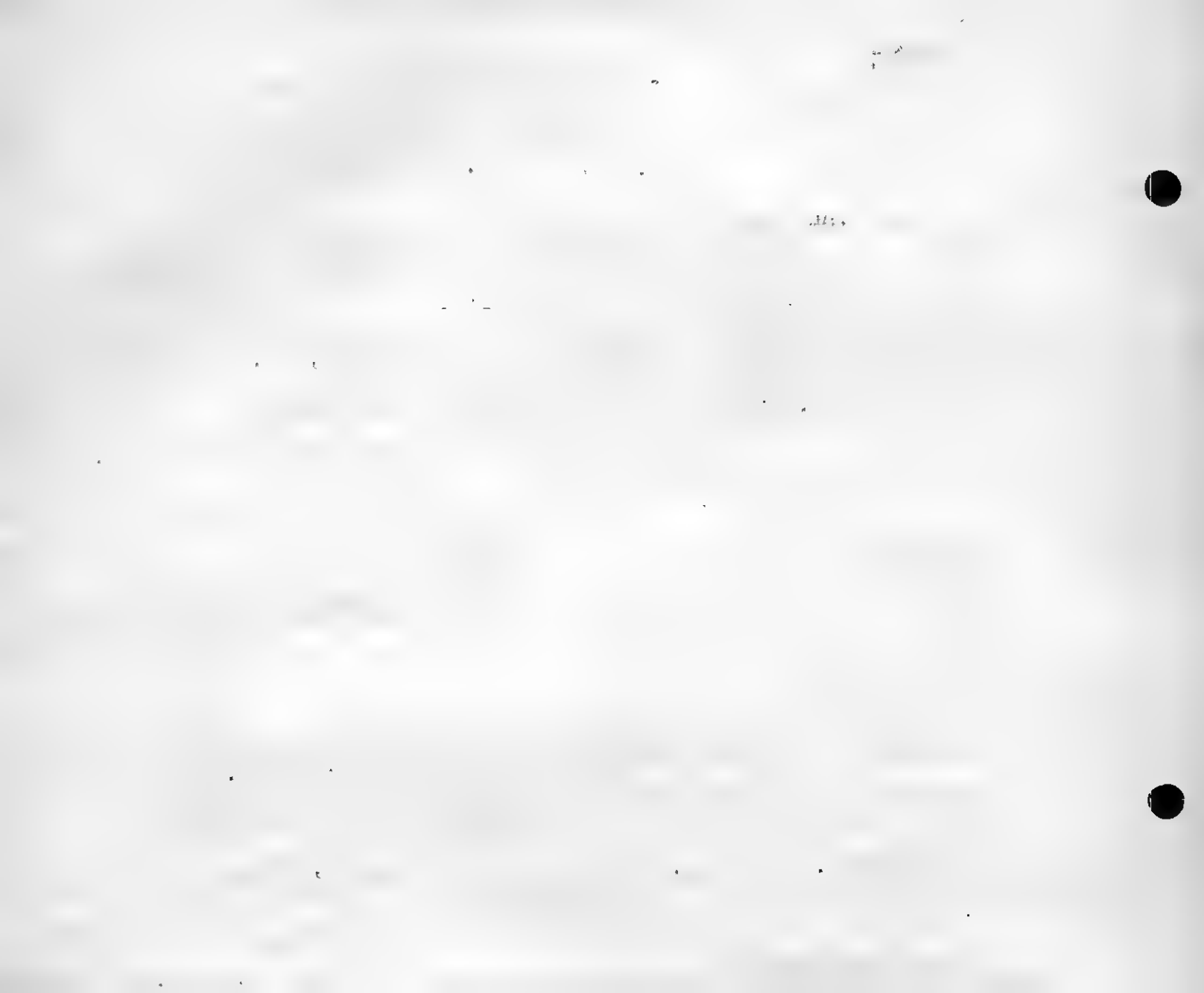
CERTIFICATE OF DEATH

08960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 1. HR. 30 MIN. CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 511	
3 NAME OF DECEASED (Type or print) First BABY Middle GIRL Last ROOT		4. DATE OF DEATH Month JULY Day 18 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-18-67
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.
13. FATHER'S NAME JAMES H. ROOT		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO none	17 INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Preventable Premature DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 18 July 1967 , 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 4:40 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Leland B. Ransom		22b. DATE SIGNED 27 July 67	
22c. PHYSICIAN'S NAME (Type) DR. LELAND B. RANSOM		22d. ADDRESS CUMBERLAND, MD.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 19, 1967	23c. NAME OF CEMETERY OR CREMATORY St. Hillcrest Burial Pl.	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany md
24. FUNERAL DIRECTOR James R. Seagull		25a REC'D BY REGISTRAR JUL 31 1967	
25b REGISTRAR'S SIGNATURE James R. Seagull			



08962

CERTIFICATE OF DEATH

08961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 9 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 613 SEDGWICK ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle JOSEPH Last ROSSKAMP		4. DATE OF DEATH Month JULY Day 25 Year 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-66 9. AGE (In years last birthday) 9 MOS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.
13. FATHER'S NAME EDWARD M. ROSSKAMP		14. MOTHER'S MAIDEN NAME JOAN B. GHOST	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO (b) Multiple Congenital Anomalies. DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 6:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Robert Brodell</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DR. ROBERT BRODELL		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 27, 1967	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md.
24. FUNERAL DIRECTOR Louis Stein, Inc. Cumberland, Md.		25a. REC'D BY REGISTRAR DATE AUG 1 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08963

CERTIFICATE OF DEATH

08962

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. STREET ADDRESS 413 VIRGINIA ST.	
3. NAME OF DECEASED (Type or print) First Middle Last BABY GIRL SAGAL		4. DATE OF DEATH Month Day Year JULY 13 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/12/67
9. AGE (In years last birthday) yrs 1		10. IF UNDER 1 YEAR Months Days 10 14	11. IF UNDER 24 HRS Hours Mins 10 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) ALLEGANY CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH SAGAL		14. MOTHER'S MAIDEN NAME LINDA L. DOUGLAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT HOSP. RECORD		Address SACRED HEART HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity. 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Uterine Preg. 5 mo. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/12, 19 67 to 7/13, 1967 , that (I) (we) last saw the deceased alive on 7/12, 19 67 and that death occurred at 12 M. from causes and on the date stated above.			
22a. SIGNATURE M. Kato		22b. DATE SIGNED 7/14/67	
22c. PHYSICIAN'S NAME (Type) KATO MIKIO RAXR. M/D/		22d. ADDRESS 1225-B NATL HWY, LA VALE, MD. 21504	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/19/67	
23c. NAME OF CEMETERY OR CREMATORY Allegany Co. Cem.		23d. LOCATION (City or Town) (County) (State) Cumberland Md	
24. FUNERAL DIRECTOR Louis Stein Inc. Camb. Md		25a. REC'D BY REGISTRAR JUL 24 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



08964

CERTIFICATE OF DEATH

08963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 'b 27 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS HYNDMAN	
3. NAME OF DECEASED (Type or print) First EMORY Middle F. Last SHAFFER		4. DATE OF DEATH Month JULY Day 2 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelly Springfield Tire Co. Tire Building		11. BIRTHPLACE (County & State or foreign country) HYNDMAN, PA.	
13. FATHER'S NAME WILLIAM E. SHAFFER		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO 717-09-7535	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Central arteriosclerosis (c) 2. mm		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 5, 1967 to July 2, 1967 that (I) (we) last saw the deceased alive on July 1, 1967 and that death occurred at 8:14 AM from causes and on the date stated above.			
22a. SIGNATURE Clay E. Durrett		22b. DATE SIGNED July 3, 1967	
22c. PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT		22d. ADDRESS 236 VIRGINIA AVE., CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 4, 1967	23c. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery	23d. LOCATION (City or Town) (County) (State) Hyndman, Bedford Co. Pa.
24. FUNERAL DIRECTOR Harvey H. Feigler		25a. REC'D BY REGISTRAR DATE JUL 10 1967	25b. REGISTRAR'S SIGNATURE James J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE CUMBERLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 17 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		e. STREET ADDRESS AVE. POTOMAC PARK	
3. NAME OF DECEASED (Type or print) DOLLIE First L. Middle SHERMAN Last		4. DATE OF DEATH Month JULY Day 11 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-24-1884
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWF.		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) MOOREFIELD, WEST VA.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME JESSE HEAVENER		15. MOTHER'S MAIDEN NAME MARY POPE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		17. SOCIAL SECURITY NO. 220-10-0912	
18. INFIRMARY PATIENTS HOSPITAL CHART		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) apoplectic stroke DUE TO (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 4 weeks 2 1/2 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-13-1967 , to 7-11-1967 , that (I) (we) last saw the deceased alive on 7-11-1967 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE L. Brings		22b. DATE SIGNED 7-11-67	
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.		22d. ADDRESS 57 GREENE STREET, CUMBERLAND, MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/67	
23c. NAME OF CEMETERY OR CREMATORY Olive Hill Cemetery		23d. LOCATION (City, town or county) (State) Moorefield, W. Va.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR JUL 13 1967	
ADDRESS 280 Balto Ave., Cumberland Md		25b. REGISTRAR'S SIGNATURE John J. Hafer, Jr.	

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS FLINTSTONE	
3. NAME OF DECEASED (Type or print) First JOHN Middle M. Last SHIPWAY		4. DATE OF DEATH Month JULY Day 7 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-1915
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months 3 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) MECHANIC		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
11. BIRTHPLACE (County & State, or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN T. SHIPWAY		14. MOTHER'S MAIDEN NAME BELLE SMITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W W 2		16. SOCIAL SECURITY NO 213-30-0142	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Terminal Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Primary in left oro-pharynx (b) 3 yrs DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-3 , 19 67 , to 7-7 , 19 67 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 7:30 PM from causes and on the date stated above.			
22a. SIGNATURE <i>A.J. Mirkin</i>		22b. DATE SIGNED 7/9/67	
22c. PHYSICIAN'S NAME (Type) A.J. MIRKIN, M.D.		22d. ADDRESS 115 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/10/67	
23c. NAME OF CEMETERY OR CREMATORY Piney Plains Cemetery		23d. LOCATION (City or Town) (County) (State) Allegany Md.	
24. FUNERAL DIRECTOR John J. Hafer, Jr.		25a. REC'D BY REGISTRAR JUL 11 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		26. ADDRESS 230 Balto Ave., Cumberland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

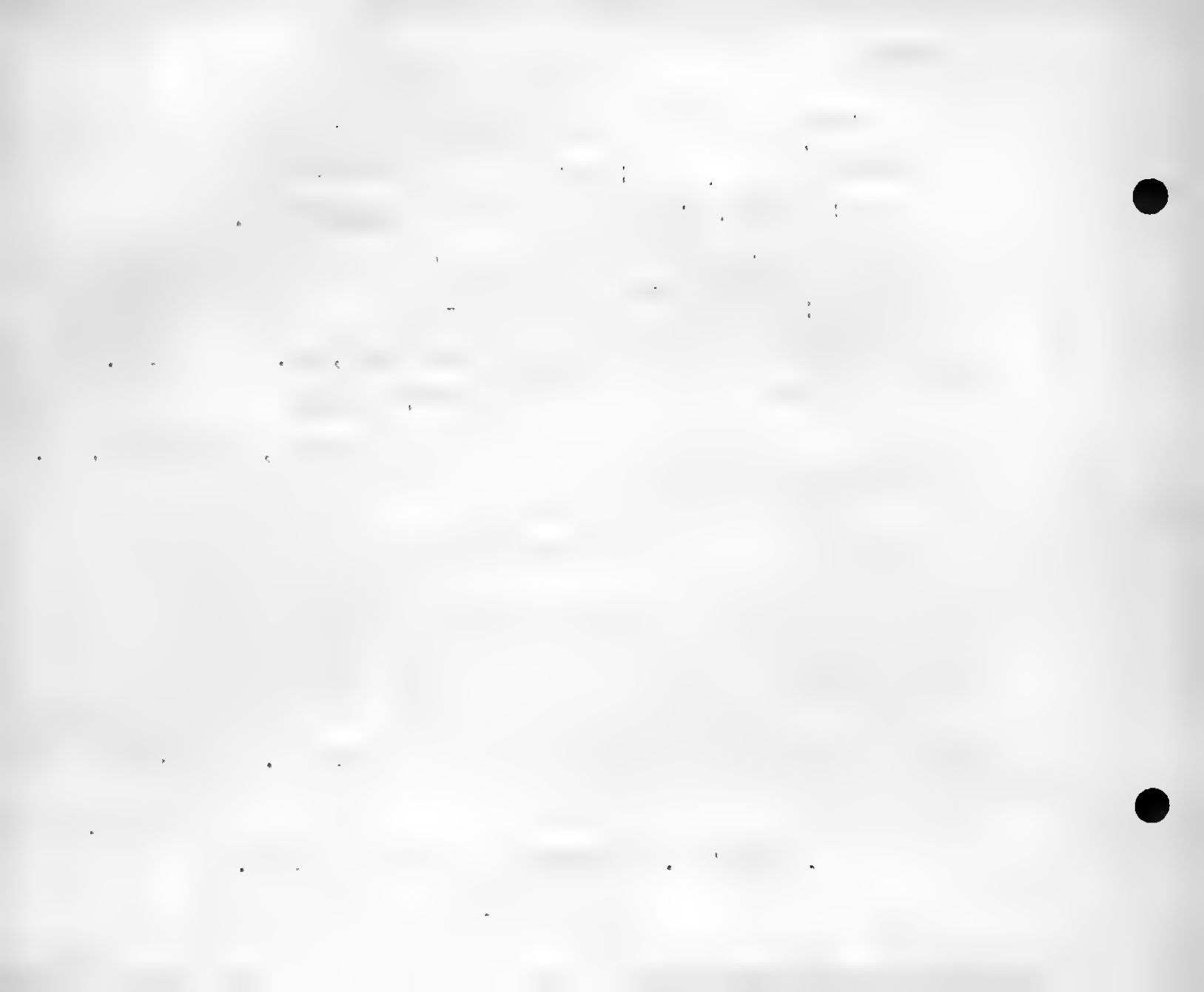
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08967

CERTIFICATE OF DEATH

08966

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 DAY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		d. STREET ADDRESS 810 SUNBURY AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL Middle W Last SINES		4. DATE OF DEATH Month JULY Day 24 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-97 9. AGE (In years birthday) 70 yes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Caterers Corp of Am	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME AARON SINES		14. MOTHER'S MAIDEN NAME CARRIE HARDEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO —	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Arteriosclerosis DUE TO (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemorrhagic Anemia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 23, 1967 5:42 P.M. July 24, 1967 that (I) (we) lost saw the deceased alive on July 24, 19 67 and that death occurred at — M, from causes and on the date stated above			
22a. SIGNATURE Samuel M. Jacobson		22b. DATE SIGNED July 26, 1967	
22c. PHYSICIAN'S NAME (Type) DR. SAMUEL M. JACOBSON		22d. ADDRESS CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 7/28/67	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.	23d. LOCATION (City or Town) (County) (State) Cumberland Md.
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. REC'D BY REGISTRAR AUG 1 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08868

08867

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institutional on Residence before admission) a STATE MARYLAND b. COUNTY ALLEGANY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b 60 YEARS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital--DOA		d STREET ADDRESS ALGONQUIN HOTEL	
3 NAME OF DECEASED (Type or print) First RALPH Middle G. Last SMELTZ		4 DATE OF DEATH Month JULY Day 16 Year 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH DEC. 15, 1894
9 AGE (In years last birthday) yrs 72		10 IF UNDER 1 YEAR Months Days Hours Min.	11 IF UNDER 24 HRS. Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10b KIND OF BUSINESS OR INDUSTRY BROKERAGE HOUSE	
11 BIRTHPLACE (State or foreign country) FROSTBURG, MD.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES A. SMELTZ		14 MOTHER'S MAIDEN NAME MARGARET GUNTER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO 214 05 4028	
17 INFORMANT W. H. KIGHT		Address CUMBERLAND, MD.	
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 4201 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO (b) CORONARY SCLEROSIS DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED July 16, 1967		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Cumberland, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JULY 19, 1967	23c NAME OF CEMETERY OR CREMATORY FROSTBURG MEMORIAL PARK	23d LOCATION (City or Town) (County) (State) FROSTBURG, MD.
24 FUNERAL DIRECTOR BYRON KIGHT		25a REC'D BY REGISTRAR DATE JUL 24 1967	
ADDRESS CUMBERLAND, MD.		25b REGISTRAR'S SIGNATURE Charles George	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove your papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08969

CERTIFICATE OF DEATH

08968

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 22 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 323 CITY VIEW TERRACE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA E. ARL SPARKS		First Middle Last		4. DATE OF DEATH Month JULY Day 25 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-22-81		9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME MARRY*ROHM* MIRAM ROHM				14. MOTHER'S MAIDEN NAME LAVINA BATZEL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (No) (unknown)) NO		16. SOCIAL SECURITY NO 208-07-0850		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 1538 IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 17	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-17-67 , 19 67 at 8:25 P.M. , that (I) (we) last saw the deceased alive on 7-17-67 , and that death occurred at _____ M, from causes and on the date stated above							
22a. SIGNATURE DR. BLANE SCHINDLER				22b. DATE SIGNED 7-17-67			
22c. PHYSICIAN'S NAME (Type) DR. BLANE SCHINDLER				22d. ADDRESS CUMBERLAND, MD.			
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF JULY 28, 1967		23c. NAME OF CEMETERY OR CREMATORY PROVIDENCE CEMETERY		23d. LOCATION (City or town) (County) (State) R.D.2, EVERETT, BEDFORD, PA	
24. FUNERAL DIRECTOR MARLENE M. SOWERS				25. RECEIVED BY REGISTRAR AUG 1 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones	
60 W. MAIN, FROSTBURG, MD.							

08969

CERTIFICATE OF DEATH

08970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

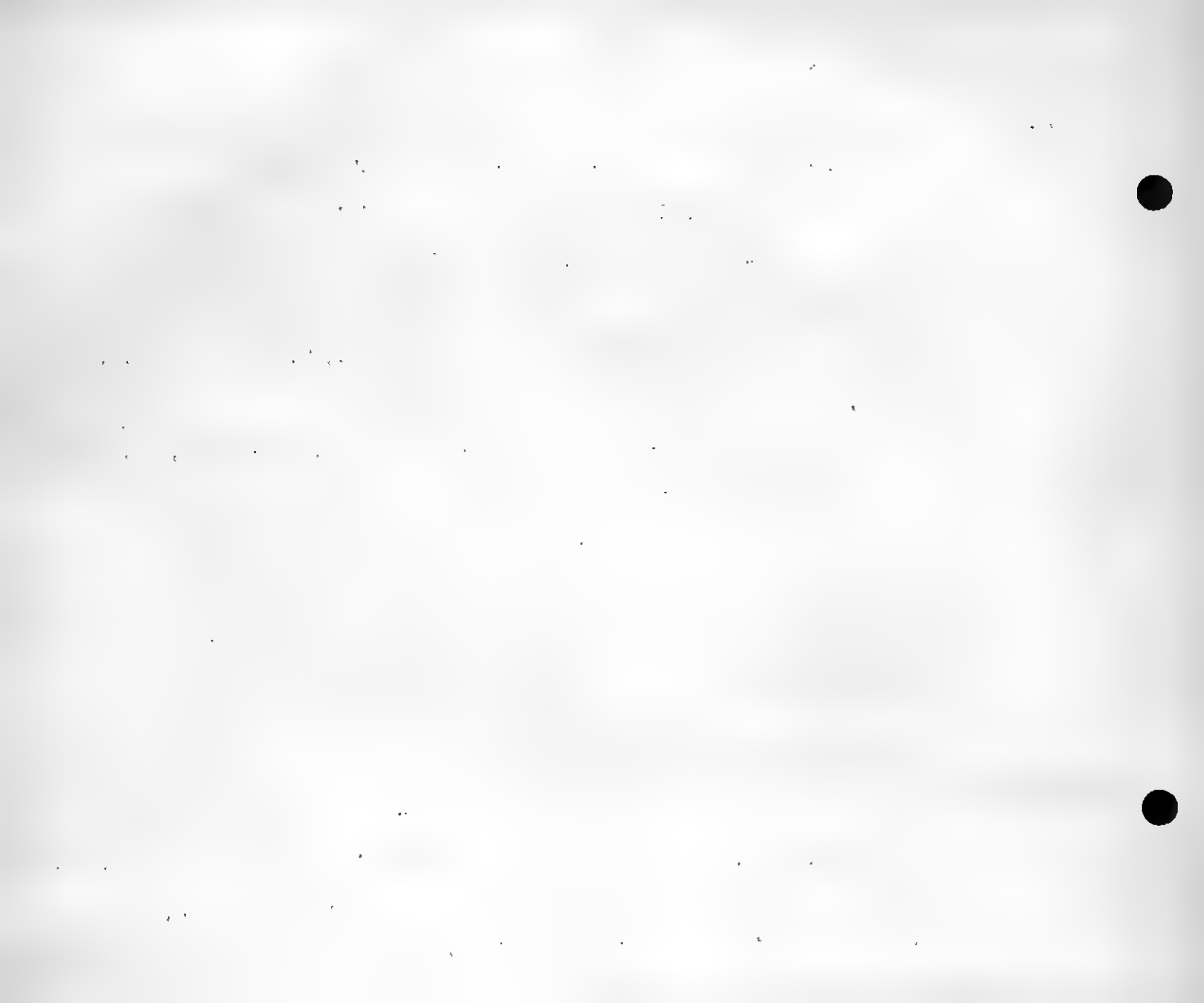
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 6 Mon.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 503 Roberts St.				d. STREET ADDRESS 90 Douglas Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucille Middle Eleanor Last STAKEM				4. DATE OF DEATH Month July Day 22nd Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1911		9. AGE (in years lost birthday) 56 yrs	10. IF UNDER 1 YEAR Months 7 Days 12 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Allegany-Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert F. Mitchell				14. MOTHER'S MAIDEN NAME Mary S. Spiers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 219-03-8345		17. INFORMANT Address Mrs. June Brown-Westernport, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular Collapse Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) terminal Ca of Ovary with (c) metastasis						INTERVAL BETWEEN ONSET AND DEATH April/66 Apr July 27/67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April , 19 66 , to July , 19 67 , that (I) (we) last saw the deceased alive on April 15 , 19 67 , and that death occurred at 7:23 M, from causes and on the date stated above.							
22a. SIGNATURE Americo Valdes		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/23/67			
22c. PHYSICIAN'S NAME (Type) Americo Valdes		22d. ADDRESS Algonquin Hotel Cumberland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/24/67		23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland Md.	
24. FUNERAL DIRECTOR Frank				ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE JUL 25 1967	
				25b. REGISTRAR'S SIGNATURE Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
08971											
Items 8, 9, 13 & 14 with 2200 7/27/67											
08972											
1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND				b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 22HRS., 45 MIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 1216 LAFAYETTE STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last INA A. STEWART				4. DATE OF DEATH Month Day Year 7 12 19 67							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/15/07		9. AGE (In years last birthday) 60 6/1 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK				10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (County & State, or foreign country) TUCKER CO., W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES E. Dyer						14. MOTHER'S MAIDEN NAME Alva White					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 220-16-6038		17. INFORMANT Address SETON DRIVE HOSPITAL RECORD, CUMBERLAND, MD. 21502					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Severe Hypertensive Cardiovascular CVD DUE TO (c) Diabetes Mellitus severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent CVA Diabetic Acidosis (Coma) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/17 , 19 67 to 7/12 , 19 67 that (I) (we) last saw the deceased alive on 7/12 , 19 67 , and that death occurred at 4:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE [Signature]				22b. DATE SIGNED 7/13/67							
22c. PHYSICIAN'S NAME (Type) DR. J. A. PAGAN				22d. ADDRESS 5 POTOMAC STREET, RIDGELEY, W. VA.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-15-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md. Allegany					
24. FUNERAL DIRECTOR SILCOX FUNERAL HOME				25a. REC'D BY REGISTRAR DATE JUL 17 1967		25b. REGISTRAR'S SIGNATURE [Signature]					



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

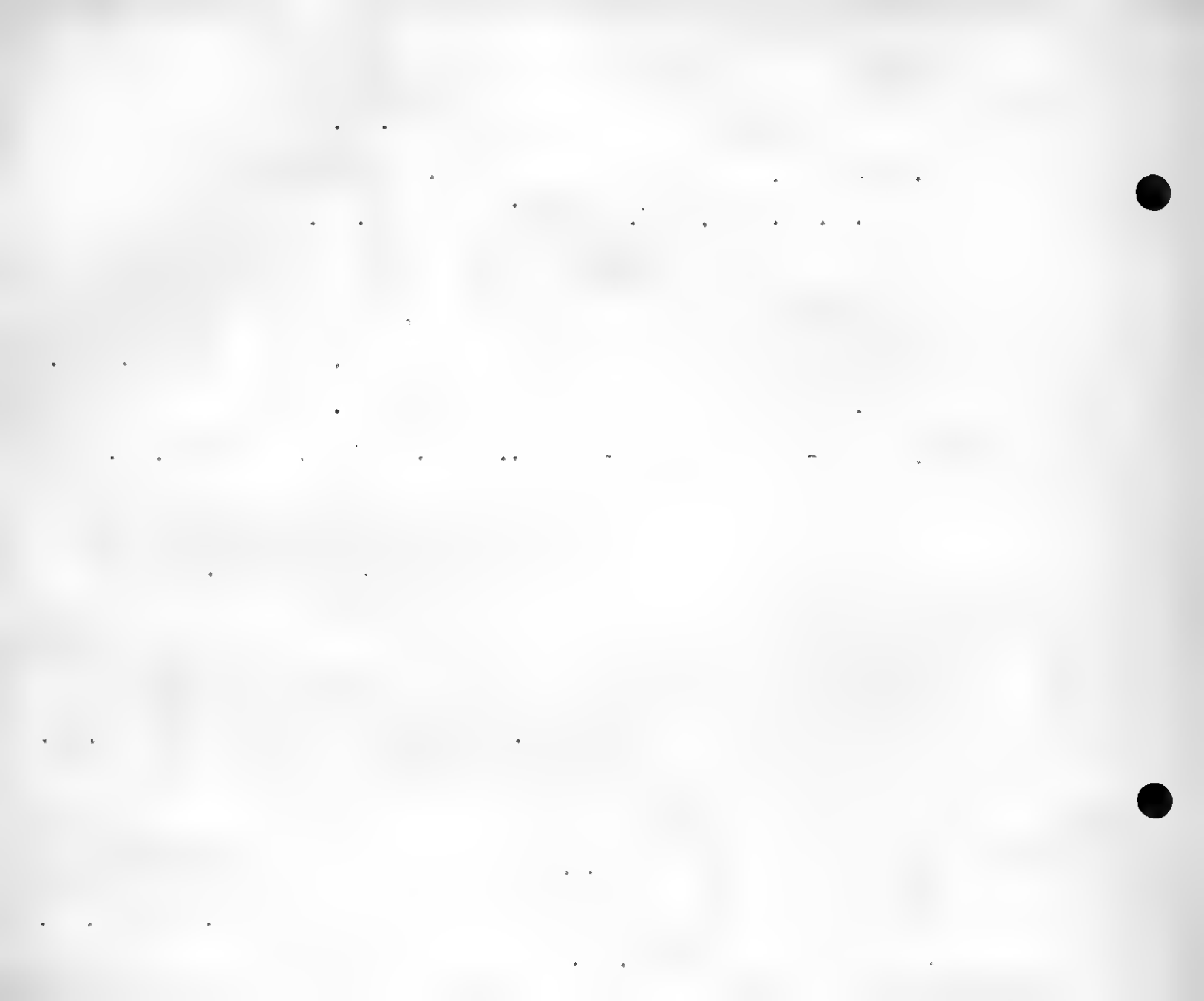
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08972

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08971

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE W. Va. b COUNTY Mineral	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) nr. Cumberland,		c LENGTH OF STAY N 1b Rt. # 1 Ridgeley,	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cumb. Along U. S. Rt. # 40, 4 mi. East of		d STREET ADDRESS Along St. Rt. # 28	
3 NAME OF DECEASED (Type or print) Larry Raymond VanMeter		4 DATE OF DEATH Month July Day 22 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1943
9. AGE (In years lost birthday) 24 yrs		IF UNDER 1 Year Months Days Hours Min IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Glass Pittsburgh Plate	
11 BIRTHPLACE (State or foreign country) Cumberland,		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ray W. VanMeter		14. MOTHER'S MAIDEN NAME Virginia E. Lease	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes, 1962-64		16. SOCIAL SECURITY NO 218-40-3241	
17. INFORMANT Mrs. Ray W. VanMeter, Cresaptown, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax, Bilateral DUE TO (b) Transection of Thoracic Spine DUE TO (c) and posterior fracture of Ribs.		INTERVAL BETWEEN ONSET AND DEATH Minutes Sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRINCIPAL OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver involved in single motorcycle accident	
20c. TIME OF INJURY Month, Day, Year Hour pm July 22 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. #40, 4 miles East, Cumberland, Alleg. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> July 22, 1967 Address (Street, city, town or county) Cumberland, Maryland	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 7/25/67	23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUL 26 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	



08973

CERTIFICATE OF DEATH

08972

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c LENGTH OF STAY in 1b 1/18/1963	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e STREET ADDRESS 156 Frederick Street	
3 NAME OF DECEASED (Type or print) First Lester Middle Wilbur Last Wade		4 DATE OF DEATH Month July Day 21 Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/3/1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Painter		10b. KIND OF BUSINESS OR INDUSTRY Celulose Corp of Md.	9 AGE (in years last birthday) 75 yrs
11. BIRTHPLACE (County & State, or foreign country) Frostburg, Maryland		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Owen Horse Wade		14. MOTHER'S MAIDEN NAME Nora E. Rice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599, Cumberland, Md. 21502		Allegany County Infirmary records.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Encephalitis DUE TO (b) Chronic Pulmonary Heart Disease DUE TO (c) Chronic Destructive Pulmonary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Smile A.S. approx 53 tract bleeding approx 3 mths			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH approx. 5-10 yrs. approx 10-15 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/18/1963 , 19____, to 7/21/1967 , 19____, that (I) (we) last saw the deceased alive on 7/21/1967 , 19____, and that death occurred at P. M., from causes and on the date stated above			
22a. SIGNATURE John A. Topper, M.D.		22b. DATE SIGNED 7-22-67	
22c. PHYSICIAN'S NAME (Type) John A. Topper, M.D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE THEREOF 7/24/67	23c. NAME OF CEMETERY OR CREMATORY Willowood Burial Pl. Cumb.	23d. LOCATION (City or town) (County) (State) Md.
24. FUNERAL DIRECTOR Louis Stein Inc. Cumb. Md.		25a. RECEIVED BY REGISTRAR JUL 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones			

CERTIFICATE OF DEATH

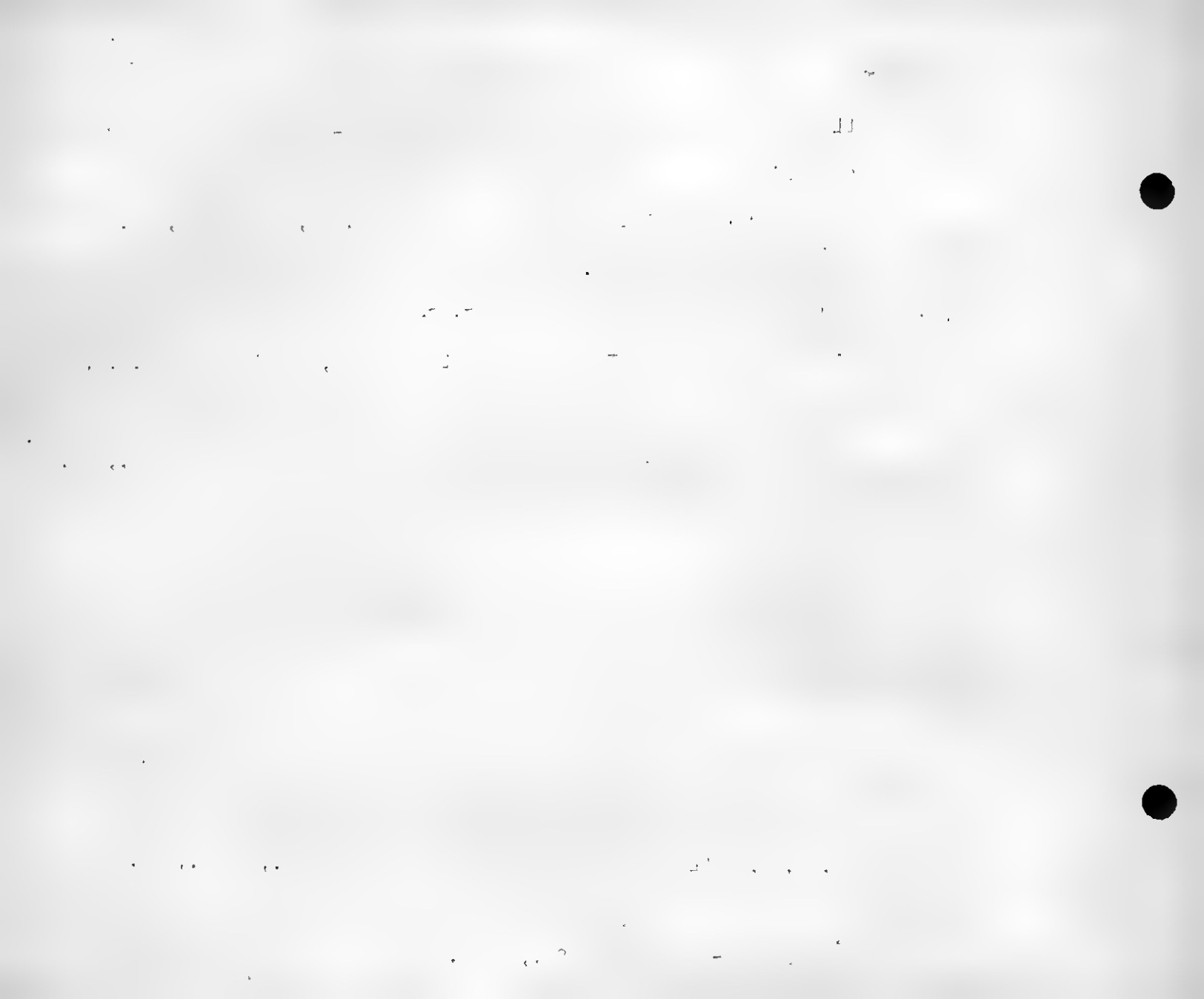
08974

08973

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS RFD. #1, FROSTBURG, MD.	
3 NAME OF DECEASED (Type or print) Rose Marie WALKER		4. DATE OF DEATH Month 7 Day 20 Year 19 67	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-21
9. AGE (In years last birthday) yrs 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BEAUTICIAN	
10b. KIND OF BUSINESS OR INDUSTRY BEAUTY SALON		11. BIRTHPLACE (County & State or foreign country) CLARYSVILLE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BERNARD MARTIN	
14. MOTHER'S MAIDEN NAME HILDA (DELANEY) MARTIN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO 216-18-1629		17. INFORMANT HOSPITAL RECORD	
18. ADDRESS 900 SETON DR. CUMB., MD.		19. INTERVAL BETWEEN ONSET AND DEATH 5 DAYS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331A DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ACVD BRONCHIAL ASTHMA			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3 - 14 , 1955 , to 7 - 19 , 1967 , that (I) (we) last saw the deceased alive on 7 - 19 1967 , and that death occurred at 1 A M, from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. R. W. Ballin</i>		22b. DATE SIGNED 7-20-67	
22c. PHYSICIAN'S NAME (Type) DR. R. W. BALLIN		22d. ADDRESS 62 GREENE ST., CUMB., MD. 21502	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/22/67	23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	23d. LOCATION (City or Town) (County) (State) Frostburg Allegany Maryland
24. FUNERAL DIRECTOR H. Lee Silcox SILCOX FUNERAL HOME-404 DECATUR ST., CUMB.		25a. REC'D BY REGISTRAR 24 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08975

CERTIFICATE OF DEATH

08971

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>114 Arch Street</u>				d. STREET ADDRESS <u>114 Arch Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Johanna</u> Middle <u>Weimer</u> Last <u></u>				4. DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 7, 1886</u>	
9. AGE (in years last birthday) <u>80 yrs.</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Connellsville, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charles F. Hyde</u>				14. MOTHER'S MAIDEN NAME <u>Fannie B. O'Bryon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs. Gladys Mock, Cumberland, Md. Daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 7201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 9, 1961</u> to <u>July 14, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 12, 1967</u> , and that death occurred at <u></u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. G. Overton Himmelfright M.D.</u>				22d. ADDRESS <u>133 Virginia Ave., Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 18, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Md. Allegany</u>	
24. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>				25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

08976

08975

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b 4/9/1965		d. STREET ADDRESS 17 Valley Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gussie Middle Belle Last Welsh		4. DATE OF DEATH Month July Day 25 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/1891
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. US JAIL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Bedford County, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Emanuel Valentine		14. MOTHER'S MAIDEN NAME Belle Rice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599, Cumberland, Md. 21502 Allegany County Infirmary records.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial failure 4500 DUE TO (b) generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) hypertension			INTERVAL BETWEEN ONSET AND DEATH yes -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 9, 1965 , to July 25, 1967 , that (I) (we) last saw the deceased alive on July 24, 1967 , and that death occurred at A. M. from causes and on the date stated above.			
22a. SIGNATURE George M. Simons		22b. DATE SIGNED 7/25/1967	
22c. PHYSICIAN'S NAME (Type) George M. Simons, M. D.		22d. ADDRESS Memorial Hospital, Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/27/67	23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park	23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany Md.
24. FUNERAL DIRECTOR H. Wayne George Cumberland, Md.		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
		25b. REGISTRAR'S SIGNATURE James J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

08977

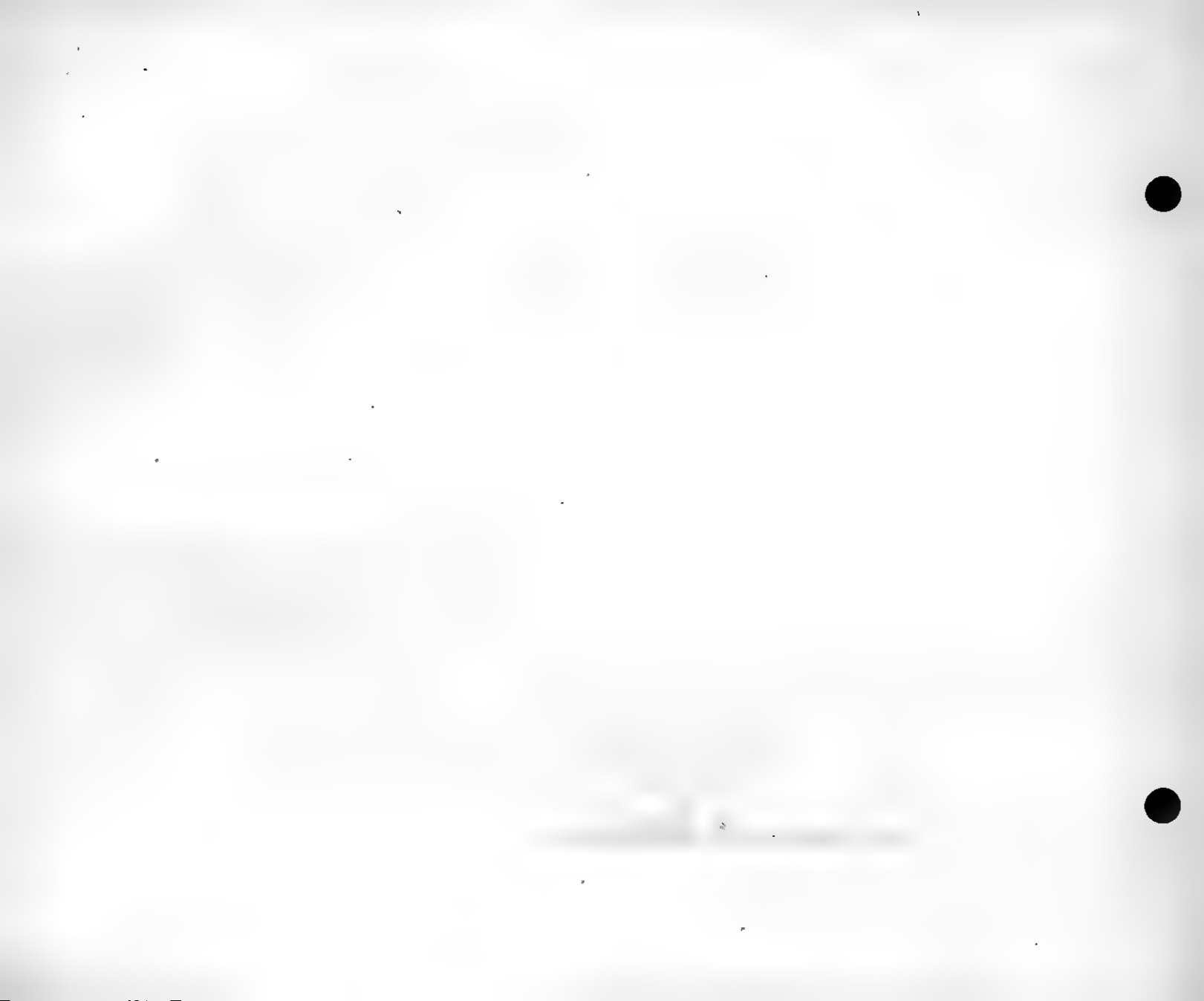
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08976

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b. COUNTY Allegany	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cumberland		c LENGTH OF STAY IN 1b 2 HRS.	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Mt. Savage
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart Hospital		d STREET ADDRESS CHURCH HILL	
3 NAME OF DECEASED (Type or print) First Middle Last Mary Nondas Williams		4 DATE OF DEATH Month Day Year July 16 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-16-05
9 AGE (In years last birthday) yrs 62		IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) MARYLAND
12 CT ZEN OF WHAT COUNTRY? USA		13 FATHER'S NAME EDWARD FANNON	
14 MOTHER'S MAIDEN NAME ANNE FARRELL		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT DANIEL WILLIAMS, MT. SAVAGE, MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours ---	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF	
23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
BURIAL		JULY 19, 1967	
ST. PATRICKS CEMETERY		MT. SAVAGE, MD.	
24 FUNERAL DIRECTOR JOSEPH R. DURST, SR., FROSTBURG, MD.		25a REC'D BY REGISTRAR JUL 20 1967	
25b REGISTRAR'S SIGNATURE Charles Judge		22 DATE SIGNED July 16, 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

28976

28977

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westernport		c. LENGTH OF STAY IN 1b 61 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Westernport	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ernest Clyde Wilson		4. DATE OF DEATH Month July Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1906
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock Washer		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill	
11. BIRTHPLACE (County & State, or foreign country) Allegany-Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry S. Wilson		14. MOTHER'S MAIDEN NAME Anna Whitesell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-05-1113	
17. INFORMANT Olara Wilson - Westernport, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO (b) Chronic Cor Pulmonale DUE TO (c) Chr. Bronch Asthma + emphysema	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 30 min 3 yrs 10 yrs	
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u>, 19<u>67</u>, to <u>July 14</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>July 14</u>, 19<u>67</u> and that death occurred at <u>1967</u> M, from causes and on the date stated above.			
22a. SIGNATURE James W. White Jr. M.D.		22b. DATE SIGNED July 14, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 7/16/67	
23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City or Town) (County) (State) Westernport, Md.	
24. FUNERAL DIRECTOR E. J. Bival ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR JUL 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remain in the funeral home. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08973

CERTIFICATE OF DEATH

08973

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 36 HOURS, 60	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS 43 CENTRAL AVE.	
3 NAME OF DECEASED (Type or print) First Middle Last ODESSA FAY WILSON		4 DATE OF DEATH Month Day Year JULY 29 19 67	
5 SEX FEMALE	6. COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/3/02
9 AGE (in years last birthday) 65 yrs		10 IF UNDER 1 Year Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11 BIRTHPLACE (County & State, or foreign country) STRAUSBURG, VA.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM SHANK		14. MOTHER'S MAIDEN NAME Kathryn Howe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-10-7590	
17. INFORMANT HOSP. RECORD		Address SACRED HEART HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Acute Pericarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Acute Pericarditis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Bronchopneumonia			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/26, 1967 , to 7/29, 1967 , that (I) (we) last saw the deceased alive on 7/29, 1967 , and that death occurred at 9 AM , from causes and on the date stated above.			
22a SIGNATURE [Signature]		22b DATE SIGNED 7/29/67	
22c. PHYSICIAN'S NAME (Type) DR. J. A. PAGAN		22d. ADDRESS MINERAL COUNTY 5 POTOMAC ST., RIDGELEY, W. VA.	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF July 31, 1967	
23c NAME OF CEMETERY OR CREMATORY Davis Memorial Park		23d LOCATION (City or Town) (County) (State) Cumberland, Md. All gany	
24. FUNERAL DIRECTOR James F. Scarcelli, Cumberland, Md.		25a REC'D BY REGISTRAR AUG 1 1967	
		25b REGISTRAR'S SIGNATURE [Signature]	

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38980

CERTIFICATE OF DEATH

08979

1 PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 12 HRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. SAVAGE	
3 NAME OF DECEASED (Type or print) First Middle Last CHARLES W. WINEBRENNER		4 DATE OF DEATH Month Day Year JULY 29 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-97
9 AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 70	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY CELANESE CORP.	
11 BIRTHPLACE (County & State, or foreign country) MT. SAVAGE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEWART WINEBRENNER		14 MOTHER'S MAIDEN NAME MARY (WINEBRENNER) WINEBRENNER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16 SOCIAL SECURITY NO. 220-10-9393	
17 INFORMANT HOSPITAL RECORD		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 104.23			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-29, 1967 , to 7-29, 1967 , that (I) (we) last saw the deceased alive on 7-29, 1967 , and that death occurred at 8 P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 8-1-67	
22c. PHYSICIAN'S NAME (Type) DRS. GLICK, SPIGGLE & VINCENT		22d ADDRESS 126 N. SMALLWOOD ST., CUMB., MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-1-67	
23c. NAME OF CEMETERY OR CREMATORY METHODIST CEMETERY		23d. LOCATION (City or Town) (County) (State) MT. SAVAGE, MD.	
24. FUNERAL DIRECTOR DURST FUNERAL HOME		25a. REC'D BY REGISTRAR PROSTBURG, MD.	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		DATE AUG 3 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

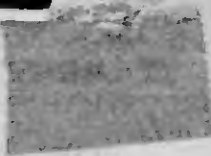
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08981

08980

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage	
c. LENGTH OF STAY IN TB 16 years		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Shannon V. Wright		4. DATE OF DEATH Month Day Year July 4, 1967 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 23, 1900
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	11. BIRTHPLACE (State or foreign country) Chaneyville, Pa.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James W. Wright	
14. MOTHER'S MAIDEN NAME Emma Ruby		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO	
16. SOCIAL SECURITY NO. 191-07-5037		17. INFORMANT Address Mrs. Velma Wright, Mt. Savage, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4701 CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO CORONARY SCLEROSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 4701			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED JULY 4, 1967 CUMBERLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8, 1967	
22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Gardens		22d. LOCATION (City, town, or country) (State) Cash Vly. Rd., La Vale, Md	
23. FUNERAL DIRECTOR <i>Harvey H. Feigler</i> ADDRESS Hyndman, Pennsylvania		24a. REC'D BY REGISTRAR JUL 10 1967 DATE <i>Charles Judge</i>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 26 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE, MD.									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL					d. STREET ADDRESS RT. #2					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First RUTLEDGE Middle NMI Last YONKER					4. DATE OF DEATH Month JULY Day 9 Year 19 67														
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-15-79		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING					10b. KIND OF BUSINESS OR INDUSTRY FARMING & LUMBER					11. BIRTHPLACE (County & State, or foreign country) LITTLE ORLEANS, MD.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME HAIRM YONKER					14. MOTHER'S MAIDEN NAME MARIAH HARDY														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 215-36-9863					17. INFORMANT HOSP. RECORD					Address SACRED HEART HOSPITAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 4200 MYOCARDIAL FAILURE IMMEDIATE CAUSE (a) DUE TO ARTERIOSCLEROTIC HEART DISEASE (b) DUE TO GENERALIZED VISCERAL FAILURE (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										INTERVAL BETWEEN ONSET OF DEATH 30 YRS. 2 MO.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS ADVANCED AGE.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) NONE														
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from JUNE 13, 1967 , that (I) (we) last saw the deceased alive on JULY 9, 1967 , and that death occurred at 8:45 A.M. , from the causes and on the date stated above.																			
22a. SIGNATURE JAMES P. HALLINAN M. D.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED 7-10-67									
22c. PHYSICIAN'S NAME (Type) DR. HALLINAN					22d. ADDRESS 140 BEDFORD ST., CUMB., MD. 21502														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 7/12/67					23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park					23d. LOCATION (City, town or county) (State) Near Cumberland, Md.				
24. FUNERAL DIRECTOR John J. Hafer, Jr.					ADDRESS 230 Balto Ave., Cumberland Md.					25a. REC'D BY REGISTRAR JUL 13 1967					25b. REGISTRAR'S SIGNATURE				

